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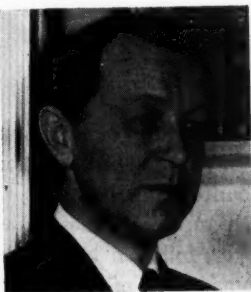
ANNUAL MEETING

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

April 26, 27 and 28, 1954

All business sessions of the Annual Meeting will be held on Monday morning and Monday afternoon, April 26th, with the exception of a short business meeting on Wednesday morning, April 28th. Between the morning and afternoon meetings of the House of Delegates on Monday, a luncheon will be served to the members of the House of Delegates.

Mrs. E. E. Cook, Chairman of the Med-Chi Faculty Ball Committee of the Woman's Auxiliary to the Baltimore City Medical Society, has again arranged for the Ball on Monday evening, April 26th, at the Alcazar. Those who attended this gala affair last year will certainly be among those present, and those who missed it, will be among the first to make their reserva-



WILLIAM L. GARLICK, M.D.



BEVERLEY C. COMPTON, M.D., *Chairman*



EDWIN H. STEWART, JR., M.D.

Committee on Scientific Work and Arrangements

tions this year. There will be a floor show, which will equal or surpass last year's. There will also be the "Coronation of Baltimore's Outstanding Student Nurse."

The House of Delegates will meet at 1212 Cathedral Street, as it did in 1953, due to the lack of space in the Faculty Building. All other functions will be in the Faculty Building, with the exception of the Round Table Luncheon, which will be held at the Sheraton-Belvedere Hotel.

The Committee on Scientific Work and Arrangements, consisting of Dr. Beverley C. Compton, Chairman, Dr. William L. Garlick and Dr. Edwin H. Stewart, Jr., are planning to have outstanding speakers and subjects of interest to all members of the Medical and Chirurgical Faculty.

On Tuesday and Wednesday mornings, from 9 a.m. to 10 a.m., Dr. Garlick has obtained interesting motion pictures. On Tuesday, from 10 a.m. to 12 noon, there will be a Psychiatric Panel on problems common to the general practitioner. The following will participate: Dr. Harry M. Murdock, Moderator, Dr. Frank J. Ayd, Jr., Dr. Klaus Berblinger, and Dr. Clifton T. Perkins.

The Johns Hopkins University School of Medicine will present a Clinical Pathological Conference on Tuesday from 2 p.m. to 3 p.m., following which there will be a Chemotherapy Panel with Dr. John C. Krantz, Jr. as the Moderator. Dr. Gladys L. Hobby, Dr. Edward P. Steers, and Dr. Henry Welch will participate on the Panel.

Dr. Bender B. Kneisley will give his Presidential Address, "Our Relations with the Public," at 8 p.m. on Tuesday evening. Following the Presidential address, Dr. Paul Dudley White of Boston will speak. In addition, a portrait of Dr. John Ruhrah will be presented.

On Wednesday morning, from 10 a.m. to 12 noon, there will be a panel discussion on Cancer, and in the afternoon from 3 p.m. to 5 p.m. there

will be a Diabetes Panel. The participants on these two Panels will be announced later. There will also be a Clinical Pathological Conference presented by the University of Maryland School of Medicine from 2 p.m. to 3 p.m. on Wednesday.

Due to popular demand the Committee has again arranged to have a Round Table Luncheon, which will be held at the Sheraton-Belvedere Hotel on Wednesday at 12:30 p.m. At this writing the following have accepted to assume the "host" position:

Dr. Warde B. Allan—Chemotherapy and Antibiotics
 Mr. G. C. A. Anderson—Civil Malpractice
 Dr. James G. Arnold—Common Neurological Lesions
 Dr. Edmund G. Beacham—Common Tuberculosis Problems
 Dr. E. S. Bereston and Dr. R. C. V. Robinson—Removal of Acne Scars (Plastic Planing)
 Dr. John E. Bordley—Nose and Throat
 Dr. Dexter M. Bullard—Psychoneuroses
 Dr. T. Nelson Carey—Diabetes
 Dr. William K. Diehl—Office Gynecology
 Dr. Monte Edwards—Proctology
 Dr. Albert E. Goldstein—Urology
 Dr. Nathan B. Herman—Industrial Medicine
 Dr. John Eager Howard—Endocrinology
 Dr. Hugh J. Jewett—Urinary Tract Cancer
 Dr. Howard W. Jones—Gynecological Carcinoma
 Dr. D. Frank Kaltreider—Breech Presentation
 Dr. Amos R. Koontz—Hernia
 Dr. John C. Ozazewski—Common Eye Problems
 Dr. Harry M. Robinson, Jr.—Common Skin Diseases
 Dr. Milton S. Sacks—Usual Laboratory Procedures in Clinical Diagnosis
 Dr. Alexander J. Schaffer—Poliomyelitis
 Dr. Douglas H. Stone—Pediatric Acute Surgical Abdomen
 Dr. Caroline B. Thomas—Hypertension
 Dr. Charles W. Wainwright—Arthritis
 Dr. Grant E. Ward—Head and Neck Cancer
 Dr. Lawson Wilkins—Pediatric Endocrinology
 Dr. Huntington Williams—Public Health
 Dr. Walter L. Winkenwerder—Allergies

Additional Round Tables are being planned, but all acceptances have not been received at the time of this announcement.

From 6 p.m. to 7 p.m. on Wednesday there will be a buffet supper, followed by a meeting with an address designed to be of interest to the members and their wives. As has been customary in the past, the President of the Woman's Aux-

iliary to the Medical and Chirurgical Faculty will be presented at this meeting.

Dr. Edwin H. Stewart, Jr. has arranged the commercial exhibits. These will be held in the tent and in the small meeting room on the lower floor of the Faculty Building.

A brand new feature—Every physician is urged to register and receive a number, as there will be

a drawing on Wednesday evening for two one hundred dollar bonds.

As you can see from the above outline, the Committee has given a great deal of thought to the preparation of this program. It is hoped that the Annual Meeting this year will be well attended, thereby assuring it as an outstanding event of the Medical and Chirurgical Faculty.

HAVE YOU PAID YOUR AMA DUES?

Resolution Adopted.

The House of Delegate of the AMA in December 1953, at the interim meeting adopted the resolution submitted by its Reference Committee on Amendments to the Constitution and Bylaws:

"Resolved, that any active member of the American Medical Association who failed to pay dues for the year 1950, and who was suspended for such delinquency, may be reinstated during the first six months of 1954 by payment of 1954 dues only.

Should such an individual fail to pay his 1954 dues by July 1, 1954, he shall continue to be considered delinquent."

Please note that the above resolution will be in effect *only* to July 1, 1954; after that date such members will again be held liable for the payment of 1950 dues if they wish to be reinstated to active membership in the A. M. A.

At this time the A. M. A. is dropping from the membership roster those physicians who have not paid 1953 dues. These physicians are being given the option of three actions:

1. To pay \$50.00 to cover membership dues in the A. M. A. for 1953 and 1954, to continue as an active member in good standing or
2. To pay \$30.00 to cover THE JOURNAL, AMA for 1953 and 1954; and be listed as a delinquent member for 1953 or
3. To pay \$15.00 to cover THE JOURNAL for 1953, to the end of the year; and be listed as a delinquent member for 1953 and THE JOURNAL stopped.

Physicians who elect either (2) or (3), will be expected to pay \$10.00 to complete the 1935 membership fee if they wish to be reinstated as a member in a future year, along with the payment required for the current year's dues.

Scientific Papers

Acute Poliomyelitis in Maryland

CLINICAL MANAGEMENT

MARTIN A. HOFFMAN, M.D.¹ AND LAURENCE FINBERG, M.D.²

Since the winter of 1949 the contagious disease center for most of Maryland has been Baltimore City Hospitals. This report is confined to experience with poliomyelitis during that period. In operating a modern communicable disease service, poliomyelitis is the only disease which is likely to present the hospital with a sudden large influx of patients. Although the season is predictable, the community incidence is extremely variable and capricious. Moreover the percentage of patients who will be seriously ill may vary considerably. Because we felt that the physicians of Maryland would be interested in the problem of hospitalization of patients with poliomyelitis, this summary of the clinical picture as we have seen it over the past four seasons is being presented. The scope of this paper is to define clearly the role of a communicable disease service of a general hospital.

During annual outbreaks of poliomyelitis the institution serves a dual role: first, to provide hospitalization for patients in the acute phase of the illness and such early convalescent care as may be indicated; secondly, to function as a diagnostic center to which physicians in Baltimore and in the various counties (particularly those who by their proximity or lack of facilities are in need of such a center) may refer patients for the necessary procedures and consultation to establish a diagnosis.

¹ Resident in Pediatrics, Baltimore City Hospitals.

² Assistant Chief of Pediatrics, Baltimore City Hospitals and Instructor in Pediatrics, Johns Hopkins University School of Medicine.

Since 1950 there have been 761 patients with poliomyelitis admitted. This accounts for a large proportion of the patients with poliomyelitis hospitalized in both Baltimore and Maryland. Statistics for 1953 from the Baltimore City Health Department and the State Health Department reveal that hospitals within the city of Baltimore (excluding Baltimore City Hospitals) admitted 17 patients with poliomyelitis and hospitals in the various counties admitted 20 such patients.³

During each poliomyelitis season the facilities of Baltimore City Hospitals are utilized for the referral of suspected cases of poliomyelitis. By performing diagnostic lumbar punctures, and such hematological and radiological studies as seem indicated, efforts are made to provide a diagnosis. The majority of those patients diagnosed as having poliomyelitis are admitted to the hospital. Those not admitted may fall into one of two categories: (1) patients without paralysis whom the physician feels will probably not develop muscular weakness and who may be readily managed at home and (2) patients with paralytic poliomyelitis who are past the acute phase of their illness and for whom arrangements can be made for the necessary physical therapy when indicated.

Emphasis is placed on admitting to the hospital all poliomyelitis patients in the acute phase of their illness who have definite or suspected

³ This excludes Montgomery and Prince George Counties, who had 44 and 33 patients, respectively, admitted either to local hospitals or to hospitals in Washington, D. C.

bulbar involvement. These patients may present with difficulty in swallowing, nasal voice, facial nerve weakness, accumulation of pharyngeal secretions or ophthalmoplegia. Weakness of muscles innervated by the upper cervical cord or the presence of encephalitic manifestations are ominous additional warning signs.

Confirmation of the referring diagnosis has been made in approximately two thirds of those patients sent in as having poliomyelitis. Among the remainder a variety of other illnesses was diagnosed and the patient was either admitted to Baltimore City Hospital or referred back to his physician. These illnesses included: acute bacterial and tuberculous meningitis, polynuritis, meningismus accompanying pneumonia, rheumatic fever, acute osteomyelitis, lead poisoning, viral encephalitis (especially mumps), fractures, soft tissue trauma, and hysteria.

WEEKLY ADMISSION RATES

A graph (Fig. 1) presents a comparison of weekly admissions of poliomyelitis patients to Baltimore City Hospitals in each of the three peak years 1950, 1952, and 1953.

GEOGRAPHICAL DISTRIBUTION OF PATIENTS

Table I presents the number of poliomyelitis patients admitted annually from 1950 through 1953 to the medical and pediatric services from the city of Baltimore and from various counties within the state. In the four year period 53% of those admitted were residents of Baltimore, 27% of Baltimore County, and the remaining 18% of 18 other counties.

CLINICAL CLASSIFICATION OF PATIENTS ADMITTED

The various categories of poliomyelitis patients admitted to each service in the four year period is illustrated in Table II. The diagnosis of non-paralytic poliomyelitis is (except where virological laboratory facilities are available) a presumptive one with or without epidemiological support. Wherever possible efforts have been made to exclude other causes of similar cere-

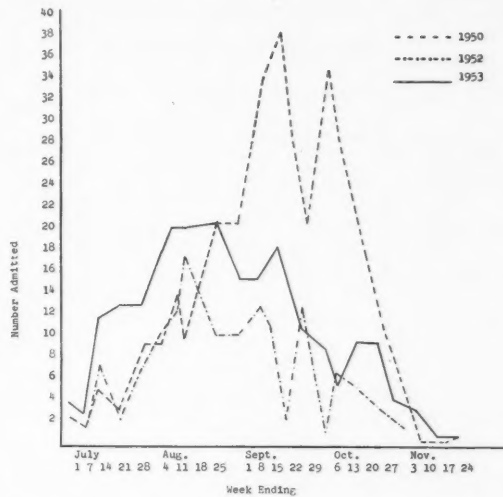


FIG. 1. Weekly admissions of poliomyelitis patients—1950, 1952, 1953

TABLE I
Geographical Distribution of Patients

AREA	1950		1951		1952		1953		TOTAL
	M	P	M	P	M	P	M	P	
Baltimore City . . .	47	168	4	12	12	45	28	86	402
Counties of Maryland:									
Allegany	1								1
Anne Arundel . . .	2	9	1			4	1	15	32
Baltimore	22	60	3	4	6	36	30	59	220
Calvert								1	1
Caroline								1	1
Carroll		6			1	1	2	2	12
Cecil		1				1		1	3
Charles				2				2	4
Frederick	2	3			3	10	2	3	23
Harford		7		1	1	6		3	18
Howard	2	1			1		3	5	12
Pr. George		1							1
Queen Anne						1		5	6
St. Mary's	2	1				1		2	6
Somerset		2							2
Talbot								2	2
Washington					1		1	1	3
Wicomico		4							4
Worcester		1			1	6			8
Total	78	264	8	19	26	111	67	188	761

M—Medical service, over 15 years of age.

P—Pediatric service, under 15 years of age.

TABLE II
Clinical Classification of Patients

	NON-PARALYTIC		SPINAL PARALYTIC		BULBAR		TOTAL
	No.	Per cent	No.	Per cent	No.	Per cent	
1950	92	27	201	59	49	14	342
1951	10	37	14	52	3	11	27
1952	36	26	77	56	24	18	137
1953	76	30	120	47	59	23	255
Total....	214	28	412	54	135	18	761

TABLE III
Age Distribution of Patients in 1950 and 1953

	1950		1953	
	No.	% of total	No.	% of total
Under 1 yr.....	12	3.5	6	2.4
1-4.....	83	24.2	74	29.1
5-9.....	120	35.1	75	29.4
10-14.....	49	14.4	33	12.8
Over 15.....	78	22.8	67	26.3

brospinal fluid abnormalities. The following data was obtained in a group of patients and their contacts studied in 1952.⁴ Type I virus was the predominant, if not the only, infecting agent as judged from stool isolations, blood isolations and serological studies. Of 29 contacts of cases of paralytic poliomyelitis, ten converted from no antibody level to a significant titer and only seven had no evidence of type I antibodies in two bleedings one month apart. This is in contrast to 30 "non-paralytic poliomyelitis" cases and contacts in whom there was only one converter and 18 who showed no antibody titer in two weeks. It seems likely additional patients could be removed from the diagnostic classification of poliomyelitis if detailed virological studies become available on a wide scale in the near future.

The bulbar category includes those patients

⁴ Unpublished data obtained in collaboration with Dr. David Bodian, Johns Hopkins University School of Hygiene and Public Health, who applied the tissue culture neutralizing antibody techniques as well as performing the viral isolation studies mentioned.

who had both bulbar and spinal involvement. It is readily seen from the table that the percentage of patients with bulbar manifestations can vary over a wide range. This is particularly important inasmuch as the most severely ill patients fall in this class.

AGE DISTRIBUTION

Table III shows the age distribution of patients who were hospitalized in 1950 and 1953. Similar distributions prevailed in the other years that were studied. In the four year period ages ranged from four months to 65 years.

MANAGEMENT OF Milder FORMS OF THE DISEASE

In those patients whose life is not threatened by bulbar or respiratory muscle paralysis, the management is directed toward relief of symptoms, accurate periodic re-appraisal of the extent of involvement, control of metabolic derangements, and support of the morale.

Urinary retention is not uncommon in lower spinal involvement. In children the parasympatheticomimetic drug, furmethide®, was found useful in doses of one to six mgm. Occasionally catheterization was necessary, particularly in the older patients. Constipation was frequently encountered and treated with enemas. Painful muscles from hyperextension and "spasm" were aided in some instances by moist heat applications, at times with analgesics, and occasionally with splints. Patients with mild pharyngeal muscle paralysis were adequately managed by mechanical suctioning of oropharyngeal secretion plus proper guidance of oral intake.

Physical therapists valuably assisted the medical staff in assessing muscle involvement and, thus, in the decision for ultimate disposition. Little physical therapy as such, was carried out during the early acute stage, but in the more severe cases and in those where a complication prolonged the stay, the avoidance of contractions and early re-education of the patients in muscle use were stressed.

TABLE IV
Deaths and Case Fatality Rates

YEAR	AGES										TOTAL	
	Under 1 yr.		1-4 yrs.		5-9 yrs.		10-14 yrs.		15 yrs. & over			
	Deaths	% Mortality	Deaths	% Mortality	Deaths	% Mortality	Deaths	% Mortality	Deaths	% Mortality	Deaths	% Mortality
1950	1	8	0	0	2	2	0	0	5	6	8	2.4
1951	0	0	0	0	0	0	0	0	0	0	0	0
1952	0	0	0	0	1	3	0	0	3	12	4	2.9
1953	0	0	1	1	3	4	3	9	6	9	13	5.1
Total	Under 15: 11 deaths, 2% mortality								14	8	25	3.3

In patients in whom there was extensive paralysis of three or four extremities attention was given to the problem of calcium balance. At present such studies remain in the field of clinical and biochemical investigation, but hypercalcuria and early osteoporosis can be detected during the subacute stages of the illness.

Psychological factors appear of great importance in the moderately ill patients with poliomyelitis. Limited personnel, under the conditions of a large outbreak, restrict the scope of aid that can be accomplished. Volunteer groups were helpful in this respect at times.

MANAGEMENT OF SEVERE FORMS OF THE DISEASE

The patients with extensive bulbar involvement, paralysis of the muscles of breathing, or a combination of these are the most severely ill. Either a tracheotomy, a mechanical respirator, or both is generally needed in their management. In 1953 there were a total of 23 tracheotomies performed, 17 in adults and 6 in children. This procedure was felt to be especially indicated in those patients in whom an adequate airway could not be maintained otherwise, either because of weakness of the pharyngeal musculature and depression of the cough reflex or increasing stupor with subsequent aspiration of pharyngeal and buccal secretions. Each patient on whom a tracheotomy was performed thereafter required constant nursing vigil with emphasis placed on keeping the tracheotomy tube

clean and free of secretions and on prevention of infections of the tracheotomy wound. Antibiotics were used in the prophylaxis of pneumonia, tracheitis, and mediastinitis. Effort was also made, at least initially, to provide an atmosphere of high humidity to minimize the occurrence of viscid secretions.

In 1953 twelve pediatric and sixteen adult patients were placed in tank respirators. Nurses were constantly in attendance to ensure the continuous operation of the respirators under specified conditions and to help prevent such complications as hypostatic pneumonia and decubitus ulcers. All the adults placed in respirators received a tracheotomy to facilitate their subsequent nursing care. Many respirator patients were initially maintained on parenteral fluids and attention was directed at maintaining their electrolyte balance and assessing the respiratory acidosis and alkalosis so frequently occurring in such patients. Aspiration pneumonia is a common and often troublesome complication. In fulminant cases it may appear very early and play an important role in the mortality.

TABLE V
Disposition of Surviving Patients 1953

	HOME		ORTHOPEDIC HOSPITALS	
	No.	%	No.	%
Medical Service	32	51	31	49
Pediatric Service	94	52	87	48
Total	126	52	118	48

MORTALITY

In Table IV are given the deaths and case fatalities occurring in each year at different age ranges. With one exception, all the patients who died had either bulbar or bulbo-spinal involvement. The one exception had complete respiratory muscle paralysis without bulbar manifestations. The overall mortality for the four year period was 3.2%.

DISPOSITION OF PATIENTS

Table V shows the disposition of surviving patients on both the Medical and Pediatric Services. Kernan's Hospital for Crippled Children and the Children's Hospital School received nearly all the patients who were not discharged

home. All patients transferred in respirators were received at the Respirator Center of the Children's Hospital School.

SUMMARY

During the past four years 761 patients with acute poliomyelitis were treated as in-patients at Baltimore City Hospitals. There have been marked fluctuations in annual case loads and variations in the proportion of case types. The overall mortality was 3.2%.

An analysis of the cases treated and a discussion of their management and disposition has been presented with emphasis on the role played by Baltimore City Hospitals in the overall community program.

Musculo-Skeletal Function in Rheumatoid Arthritis¹

ROBERT L. PRESTON, M.D.²

Rheumatoid arthritis is a systemic disease, the disabling manifestations of which are almost entirely localized to the musculo-skeletal system. Therefore, the preservation or the restoration of the functional capacity of the musculo-skeletal system is of vital importance in the management of patients with this disease. A broad treatment program is required which will control the systemic aspects of the pathology as well as the local manifestations of the disease in the musculo-

skeletal system. Now that effective therapy is available for the control of the systemic rheumatoid process, it can be expected that a patient who receives the benefit of carefully correlated medical-orthopedic treatment will have an extremely good chance of recovering without significant functional disability.

The measures which are used to prevent deformity and preserve musculo-skeletal function need not be complicated or highly technical if this treatment is started at the onset of the disease and is continued consistently, without interruption, throughout the entire active course. In most instances this treatment can be prescribed and supervised by the internist who is responsible for the systemic treatment. However, if the treatment of the musculo-skeletal lesions is neglected until fixed deformity has de-

¹ Presented before the Baltimore City Medical Society on October 16, 1953, Osler Hall, Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore, Maryland. Dr. Joseph J. Bunim, National Institutes of Health, Bethesda, also appeared on this program, and his paper will be published in a later issue.

² New York, N. Y. Associate Clinical Professor of Orthopedic Surgery Post-Graduate Medical School, New York University.

veloped or if this treatment is applied sporadically, permitting periodic regression in joint efficiency, treatment which is highly technical usually becomes necessary and even with the best of luck some residual impairment of function may persist after maximum rehabilitation has been achieved. If it is necessary for the internist to call for the assistance of the orthopedist in the management of the musculo-skeletal aspect of the pathology, it is imperative for the success of the combined treatment program that the two clinicians carefully synchronize their efforts.

In the following discussion of the management of the musculo-skeletal lesions of rheumatoid arthritis, it is to be understood that each patient is under the supervision of an internist and that he is receiving systemic treatment continuously.

The treatment for the control of the musculo-skeletal lesions can be divided into five phases, which are:

1. The precise evaluation of the condition of the musculo-skeletal system at the onset of treatment, with frequent re-evaluations for the detection of any change in functional deficiency.
2. The protection of the musculo-skeletal system from unphysiological trauma by the immobilization of inflamed joints, the elimination of intra-articular and extra-articular causes of joint trauma and the control of the trauma to which the joints are exposed by protection from overuse.
3. The prevention of deformity.
4. The restoration of function.
5. The maintenance of function by the restoration of accurate muscular control and the use of protective apparatus when necessary.

In illustrating the practical application of each phase of this treatment program, the discussion will be limited to the management of lesions of the knee joint, which are the most common cause of crippling in rheumatoid arthritis.

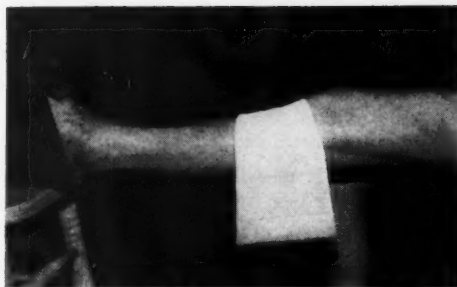


FIG. 1. Stretching the knee into hyperextension by the application of a weight of five pounds or more which is suspended from the leg, just below the knee. Effective stretching is accomplished with the use of relatively little weight if the treatment is continued without interruption for a half hour at a time. Quadriceps setting exercise is done while the knee is being stretched. Even after the range of passive extension is normal, the knee is immobilized in this manner during the quadriceps setting exercise, as this exercise is of no value unless it is performed with the knee at the limit of passive extension.

THE PREVENTION OF DEFORMITY AND THE TREATMENT OF THE SLIGHTLY DEFORMED JOINT

Let us consider first the patient with an early, low grade rheumatoid lesion of the knee which has not, as yet, produced significant functional impairment. Although there is mild limitation of motion which will need to be corrected, the principal problem is the prevention of deformity.

The treatment starts with a physical examination which includes a careful evaluation of all of the structures of the musculo-skeletal system. This examination is not limited to the knee as there may already be functional impairment of some of the other joints.

The signs and symptoms are those of any low grade irritation of the synovia of the knee; soreness when beginning to walk after prolonged rest, especially on arising in the morning, soreness on full motions or on prolonged use, excessive fatigue of the musculature of the thigh and leg, muscular atrophy, tenderness, swelling of the knee, slight limitation of active motion and slight limitation of passive motion.

We have, therefore:

1. A knee which is the site of a low grade inflammation for which rest and protection from trauma is indicated, and
2. A knee which can be held only in flexed position by reason of the loss of efficiency of the extensor muscles and the resistance to full passive extension, and
3. A knee in which the flexion deformity can be expected to increase unless measures are applied to make it possible for the patient to hold it firmly in the normal weight-bearing position of full extension.

In the presence of signs of inflammation, however slight, complete rest is indicated. The findings on physical examination determine the kind and amount of protection which is required at the onset of treatment. Most commonly, a cast is applied for a week or two and crutches are used to eliminate all weight-bearing. However, if the inflammation is very slight, motion can be permitted and the crutches used without the cast. If a cast is applied it must extend far enough proximally and distally from the knee to actually stop motion. The cast is applied with the knee at the maximum limit of extension.

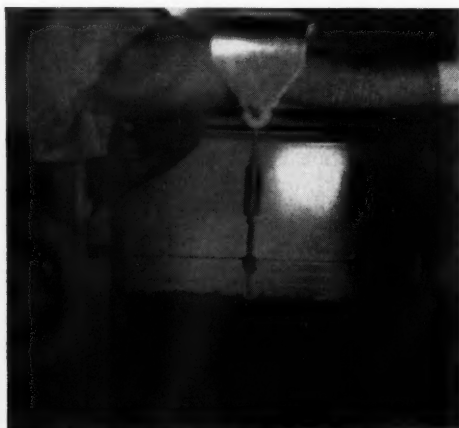


FIG. 2. A positive pressure apparatus which can be used for passive stretching of the knee, if stretching with a weight does not restore complete extension.

The Restoration of Active Muscular Control of the Joint

As weight bearing cannot be resumed until the patient is able to hold the knee firmly locked in the functional position of full extension by active muscular power, corrective exercises for the quadriceps muscle are started immediately. If the knee is immobilized in a cast, muscle setting quadriceps exercise is performed until the cast is removed. Patients with rheumatoid arthritis usually are chronically fatigued and they have little stamina. For this reason, their exercise regimen usually must be reduced to the basic essentials. Until the patient is able to lock the knee firmly in functional position, the exercises are limited to those which will contribute to the ability to extend the knee through the last 20 degrees. As fatigue develops after only a few minutes of exercise, the daily dose usually is broken up into a number of brief sessions. As soon as sufficient muscular skill has been developed to enable the patient to bring the knee actively into maximum extension, passive resistance exercises are added to the program so as to build up the strength of the extensor muscles more rapidly. The exercises are continued until normal strength and endurance have been restored.

The Restoration of Passive Motion

Treatment for the restoration of complete passive extension is started as soon as the cast is removed. Until the knee falls loosely into the position of full extension, no effort is made to restore the full range of flexion, as complete extension is essential for function but satisfactory function can be accomplished without complete flexion.

These mild flexion deformities usually can be overcome by gentle passive stretching. The patient sits on a firm chair with the foot on another chair and a ten pound weight is suspended from the leg, just below the knee, for the purpose of producing a hyperextension force. The knee is

stretched for a half hour, three times a day. During the stretching, quadriceps setting exercise is done.

If this technic is not effective, a positive pressure apparatus can be applied. In using this apparatus the patient sits in the same posture and places a sling over the front of the leg just below the knee. The sling is then pulled firmly toward the floor by means of a turnbuckle or a rope which passes through an eyelet in the floor. A strong, steady hyperextension force is produced.

In some instances it is desirable to apply traction or a posterior splint to maintain full extension when the patient is at rest in bed.

If the full range of passive extension is not restored within a few weeks, the operative treatment which is used for the correction of fixed contractures is applied without further delay, as it is essential that complete correction of the deformity be accomplished.

Flexion to just beyond the right angle is essential, as this range of flexion is necessary to enable the patient to get up from a chair with ease. If the pathological changes in the knee are slight, a normal range of flexion usually should be restored but if the knee is severely disabled, no effort should be made to restore more flexion than the basic functional essential.

If the range is markedly limited, the patient sits on the side of the table and suspends a weight from the front of his ankle, so as to produce a strong flexion strain on the knee. If the knee can be flexed to at least 135 degrees but not beyond 90 degrees, he sits on a chair with his toe against a firm object, such as the leg of a table, and slowly slides the chair forward, in such a way as to produce a flexion strain on the knee. Or, if the knee can be flexed to at least 90 degrees, he lies on his back on a firm surface, places a sling around the front of the ankle and pulls firmly on this sling to produce the flexion strain.

After the full range of passive extension and the maximum range of passive flexion have been

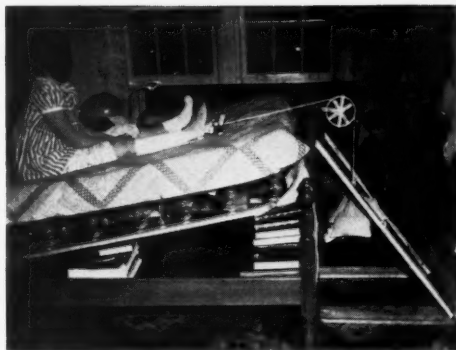


FIG. 3. Improvised traction apparatus which has been constructed with materials available in the home.



FIG. 4. Posterior splint to maintain full extension while the patient is at rest in bed at night. It should be noted that for effective control of the knee, the splint must extend from the hip to the foot.

developed, the stretching treatment is discontinued with the exception of five minutes of stretching which is continued each day for many weeks. At the first sign of loss of extension, the full therapeutic dose of stretching treatment is resumed.

The Cautious Resumption of Use of the Joint

As soon as the signs of inflammation have disappeared and the patient can extend the knee actively to the full limit, he begins to test the knee with use. The trauma to which the joint is subjected is very carefully controlled. A cane is used in the opposite hand for all weight-bearing and every step is carefully considered so as to insure relatively atraumatic function. All

arduous or complicated use is eliminated. If one knee is relatively normal, he uses this knee to lift himself up out of a chair and he goes up or down stairs one step at a time. As the efficiency of the musculature which controls the knee increases and it is demonstrated that use does not cause recurrence of disability, the activity is increased and the precautions against trauma are gradually relaxed. Careful physical examinations are made at frequent intervals so that the program can be adjusted promptly to accommodate for changing conditions.

THE MODIFICATION OF THE BASIC TREATMENT PROGRAM AS REQUIRED BY VARIATIONS IN THE PATHOLOGY

The basic treatment program has been described as it is applied to the low grade knee

joint lesion which has produced only mild inflammation, slight fixed deformity and slight muscular inefficiency. This basic program is modified to meet the conditions presented by variations in the pathology by placing more emphasis on one or another phase of the treatment. If the initial clinical study does not reveal definite signs of inflammation in or around the knee and the physical examination discloses only slight limitation of active and passive motion with only mild muscular atrophy and the patient complains of no more than mild soreness on excessive use, a cast or crutches need not be used but the patient must protect the joint from trauma and he must follow the same regimen as do the patients who are beginning ambulation after the subsidence of more severe knee joint inflammation. In the management of the acutely inflamed knee, the immobilization aspect of the treatment becomes of major importance during the period of active inflammation but after the subsidence of the inflammation, the program continues as has been outlined for the management of the more low grade lesions. And, in the treatment of the knee which is permanently contracted in deformed posture, the restoration of passive extension is the feature of major importance but once the deformity has been corrected, the program proceeds as has been outlined.

The correction of severe permanent flexion deformity of the knee presents special problems. Many operative procedures have been proposed for the restoration of passive extension to these knees, but after considerable experience with the various operations, the author has come to the conclusion that the best end-results are secured by the use of either manipulation under anaesthesia or open cutting of the restraining tissues, whichever is indicated. In general, closed manipulation is used for the correction of mild or moderately severe deformities of relatively recent origin without significant bony changes, and, open operation is used when the deformity is old and severe, when there are changes in the contours of the articular surfaces



FIG. 5. Case M. B. The patient attempting to stand prior to the operation. Although the right knee extends passively to 140 degrees, when she stands this knee is held at 110 degrees due to the extreme weakness of the extensor muscles.

or when manipulation fails to restore full extension.

THE USE OF CORTISONE OR ACTH AT THE TIME OF SURGERY

Since the introduction of cortisone and ACTH, the end-results of the surgical treatment of rheumatoid knees have improved significantly. Irrespective of the place which these hormones finally assume in the therapy for the control of rheumatoid arthritis, there is no question that they have supplied the surgeon with a therapeutic tool of primary importance. Clinical studies indicate that it is now feasible to do an operation which is extensive enough to correct all of the principal features of the pathology since there is reasonable assurance that the rheumatoid inflammation will be controlled, post-operative scar formation and edema will be inhibited and post-operative pain will be minimized. The feeling of well-being which frequently results from the use of cortisone or ACTH makes it easier for the patient to co-operate in the post-operative program which is necessary to complete the functional rehabilitation.

THE CORRECTION OF MODERATELY SEVERE DEFORMITY

The correction of knee joint deformities by manipulation under anaesthesia can be illustrated by the following report of a typical case. This 49 year old housewife (Case M. B. University Hospital #K23699), developed rheumatoid arthritis four years before she was admitted to the hospital. For about two and a half years prior to admission she had been unable to stand or walk because of the severe flexion deformities of both knees. The rheumatoid arthritis had remained moderately active since the onset.

The examination at the time of admission to the hospital revealed the condition of both knees to be approximately the same. There was moderate synovial effusion and marked synovial thickening. On palpation there was mild generalized tenderness which was most severe in the region of the fat pads on the anterior aspect of the



FIG. 6. Case M. B. The post-operative casts which were applied with the knees in complete extension, the ankles in dorsi-flexion and the feet in weight-bearing position. It should be noted that a cast for the immobilization of the knee must be long enough to extend from the groin to the ankle or the tip of the toes.

knees. Passive extension was limited by 40 degrees. There was only slight pain at the extreme of this motion. The range of active extension was 15 degrees less than the range of passive extension. Active and passive flexion was normal and there was only slight pain at the extreme of flexion. There was no crepitation, irregularity in motion or clicking on motion of the knees. Marked lateral and anterior-posterior instability was present in both knees. The musculature of the thighs and calves was markedly atrophic.

The X-rays of the knees revealed severe osteoporosis. The contours of the articular surfaces were normal with the exception of slight cuplike erosions of the central portion of the lateral plateau of the tibia on both sides, at the point of contact with the lateral condyle of the femur. There was no osteophyte formation. The bones were in normal relationship with each other.

The hips and the trunk had not been involved in the rheumatoid arthritis. The range of motion of the hips was approximately normal but the patient could bring these joints to the full limit of active hyperextension only with the greatest of effort and she could hold them in functional position only for an instant. The range of motion of the back was normal but the patient habitually sat in bed with a marked increase in the physiological curves of the spine and she could sit in erect posture only with difficulty. It was apparent that during the years of wheel-chair

existence she had lost the ability to control the trunk and hips and it was anticipated that she would have difficulty in stabilizing these joints when she became ambulatory.

The initial physical survey also revealed slight deformities in the feet, hands, and wrists which were not of functional significance and did not require treatment at that time.

From the time of admission to the hospital, the patient did corrective exercises for the musculature of the trunk and hips. These exercises were performed four times every day, with the exception of the few days after each operation. By concentrating on the reconditioning of these muscles during the first few weeks of the hospitalization, the skill and strength which was necessary for ambulation was restored promptly and this problem was disposed of before the start of the intensive exercise program for the knees.

On the day after admission to the hospital, both knees were manipulated under general anaesthesia. Only minimal force could be used and when the knees had been extended to 160 degrees, considerable resistance was encountered. In view of the extreme osteoporosis, it was decided not to attempt full correction at that time and to immobilize the knees at maximum extension. Casts were applied extending from the groin to the tip of the toes with the knees at 160 degrees, the ankles in full dorsi-flexion and the feet in weight-bearing position.

The post-operative reaction subsided rather slowly and it was twelve days before the involun-

tary muscle spasm stopped and the patient became free of pain. At that time the casts were cut at the knees and under general anaesthesia the knees were brought into 190 degrees of extension. The casts were repaired so as to immobilize the knees in this position.

After a week, the flexor muscles stopped contracting spontaneously and the casts were cut and the knees examined. Cautious motion did not stimulate spasm or significant pain so the casts were discarded and traction was applied to both legs. The traction was used whenever the patient was in bed during the remainder of the period of hospitalization. At first, the corrective exercises were limited to muscle setting of the quadriceps with the knees held in full extension. These exercises were performed six times a day and they were continued at each session to the point of moderate fatigue. After about a week, the quadriceps function having improved to the point at which it was possible for the patient to contract these muscles accurately on command, assisted quadriceps exercises were started.

The patient was not permitted to stand until she could hold the knees in the functional position of full extension. Ten days after the casts were removed she was permitted to stand, her weight being supported almost entirely by the attendants and the walker. She was not permitted to flex the knees on taking a step, as it is easier for a patient to keep the knees in weight-bearing position during the entire stride rather than struggling to extend the knee from the flexed position on every step. The stiff-leg ambulation was continued until about the time she left the hospital. The number of steps she was permitted to take was limited to those which could be accomplished with the knees held in proper position. Unlimited activity was not permitted until about ten months after operation.

She left the hospital approximately two months after admission. At that time she was able to stand on one foot, bearing all of her

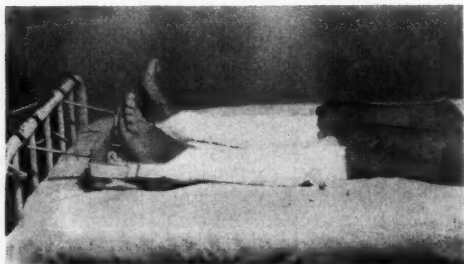


FIG. 7. Case M. B. Traction was used to maintain full correction of the flexion deformity whenever the patient was at rest in bed.

weight with the knee locked in full extension and the trunk and hip in functional position. It is not safe to discharge a patient from intensive observation until this degree of muscular efficiency has been attained. The use of traction while at rest in bed was discontinued at the time of discharge from the hospital as, by that time, the active control of the knees was so good that there seemed to be no danger of recurrence of deformity. In some cases, the traction must be continued for many months and in other cases in which the efficiency of the extensor muscles develops very slowly, braces must be worn for all ambulation for some time so as to prevent the knees from being used in deformed posture.

At the time of discharge from the hospital, knee flexion exercises and passive resistance exercises for the quadriceps muscles were started. At this time the exercise program also included free exercises for the trunk, hips and quadriceps. All of these exercises were performed to the point of definite fatigue three times a day. After six months, the trunk, hip and knee exercises were reduced to one session a day. At that time, hand, wrist, foot and ankle exercises were started. Two and a half years after discharge, she developed an exacerbation of the rheumatoid inflammation in the wrists and it was necessary for her to wear aluminum splints for six weeks. During the entire period of observation no exacerbations of inflammation occurred in any of the other joints. Three years after discharge from the hospital, the exercises for the left knee were discontinued and those for the right knee, the hips and trunk were discontinued a year later. It was recommended that the right foot, the hand and the wrist exercises be continued once a day for an indefinite period, due to the presence of irreversible deformities in these joints.

At the time of the last examination, four years after operation, there was a normal and painless range of active and passive motion in the back, hips and knees and there was no significant



FIG. 8. Case M. B. A walker was used to support most of her weight until the efficiency of the quadriceps muscles was restored.

abnormality in any of the other joints with the exception of the wrists, hands and the right foot.

This case report has been given in some detail as it illustrates the adaptation of the basic treatment program to the management of knee joint lesions which require surgical treatment for the restoration of complete passive extension. Of special interest is the long period of therapeutic exercise which was necessary in this case to stabilize the correction and ensure the maintenance of function.

THE CORRECTION OF SEVERE DEFORMITY

The correction of severe permanent flexion deformity of the knee which is complicated by severe damage to the extensor motor apparatus, extensive intra-articular adhesion formation, and marked irregularity in the contours of the articular surfaces requires extensive surgery in addition to the basic treatment program. If these joints are to function satisfactorily after



FIG. 9. Case M. B. Two months after operation. Standing with all of her weight on one foot with the knee, hip and trunk locked in functional position by active muscular power.

operation, the contracted tissues must be lengthened so that the knee can be brought into full passive extension, the physiological tension of the motor apparatus must be restored so that the joint can be moved skillfully into functional position by active muscular power, and the intra-articular causes of impaired active and passive motion in the anterior compartment must be eliminated.

Surgical Technic

For the correction of the flexion deformity, the posterior capsulotomy operation reported by Wilson (1), produces a more satisfactory result than the mere lengthening of the hamstring tendons. In this procedure the biceps femoris tendon and the fascia lata are lengthened and the posterior capsule of the knee joint and the periosteum of the posterior aspect of the lower fourth of the femur are stripped from the bone.

I have modified the technic so as to prevent post-operative lateral instability (2). This modification consists of stripping the periosteum from the posterior surface of the femur and then entering the posterior compartment of the joint from above, stripping only the posterior attachment of the capsule so as to avoid injury to the medial and lateral collateral ligaments.

The anterior compartment of the joint is then entered for the purpose of freeing the structures which must glide during joint motion. If the suprapatellar pouch or the joint cavity lateral, medial and distal to the patella are obliterated, the adhesions are cut and the intra-articular space is re-established. In order to ensure adequate room in the anterior compartment of the knee, most of the fat pad is excised. The irregularities on the articular surfaces and the osteophytes on the patella, femur and tibia are removed so as to avoid irritation of the soft

tissues which must move over the bones on motion of the knee. In some instances a considerable portion of the articular aspect of the patella is excised. Any areas of the synovial membrane which are definitely pathological also are excised.

If the patellar tendon and the quadriceps muscle have become too lax they are tightened by moving the tubercle of the tibia distally a distance of $\frac{1}{8}$ inch for every 10 degrees of flexion deformity (3).

The post-operative regimen includes immobilization in a cast for one week, with the knee in about 15 degrees of flexion to avoid overstretching of the popliteal artery. When the cast is removed, traction is applied to bring the knee into the fully corrected position. After the operation, these patients follow the same basic treatment program as do any other patients with knee joint disability of rheumatoid origin.

The Functional Results of the Surgical Reconstruction of Severely Deformed Knee Joints

The follow-up data is available on 18 knees of eleven patients upon whom the comprehensive reconstruction operation was done while the patient was under the influence of cortisone or ACTH. The irreversible pathological changes in all of these knees were severe and all of the patients were totally disabled prior to operation. Five of the patients had not been able to ambulate for some time and the remainder were using crutches. These patients have been observed for periods of six to twenty-four months since operation.

Arthrotomy of the anterior compartment of the knee was required in all of the cases. Posterior capsulotomy was not required for the correction of the deformity of five knees of three patients. The flexion deformity of these knees was slight, varying from 20 to 30 degrees, and when manipulation was attempted prior to making the incision for the posterior capsulotomy, it was discovered



FIG. 10. Double-bar brace with a Thomas ring at the upper end and a lock at the knee. This brace can be adjusted so that the weight is carried on the tuberosity of the ischium and the knee is relieved of all weight-bearing. The knee can be locked continuously in full extension or the lock can be released to permit flexion of the knee when the patient is seated.

TABLE I
The Correction of Severe Deformity of the Knee

Number of Patients.....	11
Unable to Walk Prior to Operation.....	5
Walked With Two Crutches Prior to Operation.....	6
Number of Knees Operated.....	18
Arthrotomy of Anterior Compartment.....	18
Posterior Capsulotomy.....	13
Deformity Corrected by Manipulation.....	5
Transplant of Tubercle of Tibia.....	7
End-Results (Follow-up Period—6-24 months)	
Satisfactory (82%).....	9
Unsatisfactory (18%).....	2

that the deformity could be corrected completely with the use of only mild force. It was necessary to displace the tubercle of the tibia on seven knees of four patients. In one of these cases, the tubercle was displaced at a later operation when it was discovered that the quadriceps could not be shortened sufficiently to lock the knee in full extension. With one exception, the knees which required the displacement of the tubercle were severely deformed, 50 to 80 degrees of fixed flexion being present.

Nine of the patients, or 82% had a satisfactory end-result; that is, they are able to do sufficient walking to engage in ordinary activities, with the knee held in functional position, without the development of pain and they are able to flex the knee sufficiently to climb stairs or to get up from a chair. Some of the patients in the successfully rehabilitated group use a cane for extensive walking but none of them use crutches. Five of the patients in this group have had persistent, mild to moderate rheumatoid activity throughout the entire period of observation.

Two of the patients had unsatisfactory end-results. The pathological changes in and around the knees of these patients were no more severe than those in some of the successfully rehabilitated patients. One of these patients developed intolerance to cortisone and the rheumatoid arthritis has remained persistently very active in many joints, including the knees. She has maintained a satisfactory range of active motion but the knees have been too painful for more than very limited walking. The poor end-result seems to be due entirely to the inability to control the systemic rheumatoid

arthritis. The other patient with an unsatisfactory end-result has pain only on extensive walking but she has practically no motion in the knees and there has been a 30% recurrence of flexion deformity in one of her knees. The systemic rheumatoid arthritis has remained moderately active throughout the entire period of observation but this has not seemed to be a significant factor in the end-result. The most important cause of the failure to rehabilitate this patient is a marked psychological instability which made it impossible to secure any co-operation with the post-operative muscular rehabilitation program which is essential in these cases.

SUMMARY

The basic regimen for the management of the musculo-skeletal lesions of rheumatoid arthritis has been presented and the details of the treatment described as it is applied to the early deformity, the moderately severe deformity and the lesion which has produced severe permanent deformity. All phases of this program are applied in the treatment of all of the musculo-skeletal lesions of rheumatic arthritis, the various aspects being modified as necessary to meet the conditions presented by variations in the pathology.

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NEW HEALTH COSTS IN BUDGET

The AMA Washington Letter—No. 55

The Eisenhower budget calls for a slight reduction in overall health spending for the year starting next July 1, but adds \$7 million cash, plus \$82 million contract authority for the proposed reinsurance and clinic-nursing home programs. The regular Hill-Burton program would get \$50 million, Institutes of Health about the same as this year, and VA a 10% cut.

"Breast Self-Examination"

EDUCATIONAL AND CLINICAL EFFECTIVENESS OF THE FILM

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INTRODUCTION

The art of cancer education consists not alone in knowing the value of early diagnosis and treatment but also in imparting that knowledge to the public. Despite the interest in current cancer education, have we succeeded in partially dispelling the pall of public ignorance about this dire disease? Is the effort expended upon education adequate to arouse curiosity and stimulate interest in the common danger signals of breast cancer? Until the development of a specific and reliable test for cancer, "all of us must grow more and more alert to malignancy on less and less clinical evidence." For although the discovery of a small breast tumor which is presumably early in its development is no guarantee of curability, yet fact or chances favors this probability. There is nothing quite so simple as to believe only that which we wish to believe. However, does the record of our experience with public instruction indicate a genuine desire and popular willingness to practice the principles of cancer prophylaxis?

Recent estimates indicate that this year alone, out of every five thousand people in the average American community, there will be twelve new cases of cancer (*including two women with breast cancer*), seven people will die of cancer (*including one woman with breast cancer*), and two or three people with cancer will be "cured." Cancer incidence rates indicate that breast cancer in the female is by far the commonest single organ site of predilection. Current mortality statistics reveal that 4 per cent of all women reaching the age of thirty-five are

destined to die of breast cancer (1). Despite the fact that the breast is a readily accessible surface organ only two out of five cases of breast cancer will be discovered while the tumor is still localized to the breast alone. Almost two thousand years ago Celsus said that "only the beginnings of a cancer permit of a cure." Today the correlation between time of onset, size of tumor, stage of disease and ultimate prognosis is sufficiently well defined to justify our utmost effort in attaining the earliest possible diagnosis.

An excellent educational film in color and sound entitled, "Breast Self-Examination" has been produced in recent years by the collaborative efforts of the American Cancer Society and the National Cancer Institute. This cancer control motion picture teaches women the importance of examining their own breasts by a simple technique of inspection and palpation. The method is patterned after that which physicians are taught to employ and requires only a few minutes of time *practiced regularly once a month*. In sponsoring the routine health habit of breast self-examination the vital force of public education is carried across a significant threshold—it endeavors to make every home a cancer detection center. This investigation was undertaken with the specific purpose of evaluating the effectiveness of the film "Breast Self-Examination" in educating a large group of women who saw the film under standard conditions and similar circumstances.

METHODS AND MATERIAL

The film "Breast Self-Examination" is a 16 mm. sound film in color. In its preparation,

great care was taken to avoid frightening the women who would view it (2). An attempt was made to illustrate the technique of breast examination as practiced by a physician with emphasis on thoroughness and gentleness. The demonstration of the proper method of breast examination by the physician is followed by a portrayal of how a physician may teach a patient to examine her own breasts. The final emphasis of the film is on the hopefulness of early diagnosis. The overall aim of the presentation is to encourage monthly breast self-examination as a method of detecting curable breast cancer. The film was shown during April and May, 1952, over a four week period, to approximately 3100 (98%) female employees of The Bureau of Old-Age Survivors Insurance, Social Security Administration, Department of Health, Education, and Welfare in Baltimore, under the joint auspices of the Maryland Division, American Cancer Society and the Bureau. They viewed the film in small groups of thirty to fifty individuals and each showing was accompanied by a discussion led by a surgeon experienced in the handling of breast disease. Questions by the audience were encouraged in the discussions.

At the time of the showing of the film there was no plan to assay its effectiveness and no comment about this aspect of the program was made. Approximately six months after the showing of the film there were approximately 2400 female employees who had seen the film and were still employed by the agency. However, 2358 (98%) were actually interviewed. The color and age composition of these employees was approximately the same as that of adult females of the city of Baltimore. This similarity was particularly marked in the age groups 20 to 44. These 2358 women were individually interviewed by a questionnaire designed to test the effectiveness of the film on the number and frequency of breast self-examinations performed before and after film showing and by disease found. The questionnaire was further designed to test the effectiveness, as above indicated, in terms

of the background of the individuals, and for this purpose the individual's previous experience with breast abnormalities was considered, as well as the marital status, parity, color, age, and educational level. The specific points of the questionnaire will be brought out when the results are discussed below. In order to reduce the subjective error of the interrogator, five well-trained female interrogators were used. The questioning took place over a period of about two weeks during the month of November. In order to reduce possible subjective influences on the part of the interviewee, the questionnaire was anonymous.

To measure the validity of the answers in the questionnaire regarding frequency of examination, each individual was asked the last month of examination. This answer was then correlated with the number of times the interviewee reported self-examination. There was a remarkably good correlation between the number of examinations and the month which might be expected to have been the last month of examination. We have therefore assumed that there was a reasonably high degree of validity to the answers obtained. Other internal checks of reasonability of replies to particular questions were made. These proved the general validity of the information given by the women interviewed.

It must be pointed out that this particular report differs from others previously reported in two respects. First, a large representative population was available. Second, the film was accompanied by a physician-audience discussion.

EDUCATIONAL EFFECTIVENESS OF THE FILM-PHYSICIAN DISCUSSION COMBINATION TECHNIQUE

The principal gross effect of the film showing seems to be that 80.7 per cent of the 2,358 individuals interviewed examined their breasts occasionally or frequently after the film showing, compared with 7.8 per cent who did so prior to the showing of the film (Table I).

It is reasonable to assume that this remark-

able improvement in the rate of self-examination is solely the result of this health education technique. One might question, however, whether the high reaction ratio is explained in part by individuals who practiced self-examination only on a single, or at most, two or three occasions during the six-month period. In order to clarify this, each woman who had practiced self-examination after the film was asked the number of times she had examined herself since seeing the film. Some 590 or 31 per cent reported that they had examined themselves at least six times during the six months after the film. Another 5 per cent examined themselves as many as five times during the six-month period (Table II). One might, therefore, conclude that there remained a hard core of about one-third of the total who saw the film and practiced self-examination afterward, who were influenced to practice breast self-examination with some regularity during the approximate six month period intervening between learning the technique and time of interview.

It was thought that women who had previously had breast difficulties might be more responsive to the film. However, there seemed to be a greater response to the film among women who had had no previous abnormalities than among those who had. The survey indicated that 72 per cent of the women with previous abnormalities who had not practiced self-examination before the film reported that they began self-examinations after the film. On the other hand, about 80 per cent of the women without abnormalities who had not practiced self-examinations reported self-examinations started for the first time after the film.

It was interesting to note a significant difference in response by marital status. Two thirds of the women were or had been married. Of the married women who had previously not practiced self-examination, over 81 per cent did so after seeing the film. The comparable percentage for unmarried women was 74 per cent. Furthermore, a third of the married women who examined

TABLE I
Summary Data on Rate of Self-Examination before and after Film

SELF-EXAMINATION HABIT	BEFORE FILM		AFTER FILM	
	Number	Per cent	Number	Per cent
Total	2,358	100.0	2,358	100.0
Occasionally or frequently ..	184	7.8	1,902	80.7
Not at all	2,161	91.6	447	19.0
Not reported	13	0.6	9	0.3

TABLE II
Summary Data on Number of Self-Examinations after the Film

NUMBER OF EXAMINATIONS	ALL WOMEN		WOMEN WITH SELF-EXAMINATIONS	
	Number	Per cent	Number	Per cent
Total	2,358	100.0	1908	100.0
0 times	447	19.0	—	—
1 time	309	13.1	309	16.2
2 times	320	13.6	320	16.8
3 times	340	14.4	340	17.8
4 times	238	10.1	238	12.5
5 times	111	4.7	111	5.8
6 or more times	590	25.0	590	30.9
Not reported	3	0.1	—	—

themselves after the film did so at least six times during the six month period, as compared with a fourth of the unmarried women. Parity had no demonstrable effect.

Approximately three fourths of the women were white. There was a significant difference in the response to the film by white and non-white women. While only 76 per cent of the whites who hadn't done so before the film reported self-examinations after the film as much as 88 per cent of the non-white women reported examinations started for the first time after the film. Furthermore, while nearly 29 per cent of the white women reported six or more examinations, 38 per cent of the non-whites so reported.

The most striking finding appeared by age group (Table III). The response rate was highest for the youngest age group (84 per cent) and lowest for the oldest age group (62 per cent). This percentage continued to decline steadily from youngest to oldest age group with one exception, namely, for the age group 45-54. The

TABLE III
Effect of Film on Women, by Age Group

SELF-EXAMINATION HABIT	AGE GROUP													
	Total		Under 25 years		25-34 years		35-44 years		45-54 years		55 years & over		Unknown age	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Before film	2,358	100.0	410	100.0	963	100.0	601	100.0	274	100.0	100	100.0	10	100.0
Occasionally or frequently	184	7.8	17	4.1	67	7.0	58	9.7	28	10.2	13	13.0	1	10.0
Not at all	2,161	91.6	393	95.9	895	93.0	541	90.0	243	88.7	87	87.0	2	20.0
Unreported	13	0.6	0	0.0	1	0.0	2	0.3	3	1.0	0	0.0	7	70.0
After film	2,358	100.0	410	100.0	962	100.0	601	100.0	273	100.0	100	100.0	12	100.0
Occasionally or frequently	1,902	80.7	345	84.1	797	82.8	464	77.2	226	82.8	67	67.0	3	25.0
Not at all	447	19.0	65	15.9	165	17.2	137	22.8	47	17.2	33	33.0	0	0.0
Unreported	9	0.3	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	9	75.0
Rate of response to film ¹		80.0		83.5		81.5		74.8		80.5		62.1		—

¹ Calculated by dividing number without self-examinations before film into the number in this group with self-examinations after film.

substantial falling off in the practice of self-examination about the age of 55 years may mean that in the preparation of visual aids more care should be exercised in emphasizing the increased incidence of malignancy with advancing age. Perhaps greater care in the selection of subjects of appropriate age would be desirable or similar touchstones of cancer education might be specifically designed for this vulnerable age group.

The response to the film by educational background was measured by dividing the women into three groups as to whether they had less than high school education, high school education, and one year or more of college education (Table IV). Among those who had previously not practiced self-examination, those with college education and above showed the greatest response to the film. As much as 83 per cent of them reported self-examinations after the film. The response was slightly lower among high school graduates (80 per cent). Those with less than high school education responded less favorably (75 per cent) than the high school group.

CLINICAL EFFECTIVENESS OF THE FILM

"What did you learn from seeing the film, 'Breast Self-Examination'?"

In answer to the direct question, "What did you learn from seeing the film, 'Breast Self-Examination,'" the 2,358 women gave an aggregate of 4,407 separate responses, thus indicating several answers from many individuals. With this volley of replies (1.9 per person) we classified them initially into 32 categories and finally summarized them into four categories partly in accord with the recent study of Cohart and Hill (3).

	NUMBER	PER CENT
Total Replies	4,407	100.0
1. Nothing; very little	227	5.2
2. How to examine breasts; that self-examination is possible or easy	3,407	77.3
3. Importance of early detection and regular examination	503	11.4
4. Other answers	270	6.1
a. Favorable (188) 4.2 per cent		
b. Unfavorable (56) 1.3 per cent		
c. Indeterminate (26) 0.6 per cent		

TABLE IV
Effect of Film by Educational Level

EXAMINATION HABIT AND EDUCATIONAL LEVEL	BEFORE FILM		AFTER FILM		RATE OF RE- SPONSE TO FILM (PER CENT) ¹
	Num- ber	Per cent	Num- ber	Per cent	
Total.....	2,358	100.0	2,358	100.0	80.0
Occasionally or frequently...	184	7.8	1,902	80.7	
Not at all.....	2,161	91.6	447	19.0	
Not reported.....	13	0.6	9	0.4	
Less than high school...	650	100.0	650	100.0	74.6
Occasionally or frequently...	56	8.6	506	77.8	
Not at all.....	592	91.1	143	22.0	
Not reported.....	2	0.3	1	0.2	
High school.....	1,301	100.0	1,301	100.0	79.9
Occasionally or frequently...	86	6.6	1,057	81.2	
Not at all.....	1,211	93.1	243	18.7	
Not reported.....	4	0.3	1	0.1	
One or more years of college.....	394	100.0	394	100.0	83.0
Occasionally or frequently...	42	10.7	334	84.8	
Not at all.....	352	89.3	60	15.2	
Unknown.....	13	100.0	13	100.0	
Occasionally or frequently...	0	0.0	5	38.5	
Not at all.....	6	46.2	1	7.7	
Not reported.....	7	53.8	7	53.8	

¹ Calculated by dividing number without self-examination before film into number in this group with self-examinations after film.

The results of this inquiry reveal a favorable reply (under 2, 3 and 4-a) in 4,098 instances, or 93 per cent, thus indicating that the seeds of learning have been successfully sown. Unfavorable replies (under 1 and 4-b) total 283 answers, or 6.4 per cent, and indicate learning's labor lost.

"Did you find anything abnormal when you examined your breasts?"

In answer to this question there were 58 women out of the 1,902 who examined themselves after the film or 3 per cent who indicated that they had found an abnormality within their breasts; there were 1,844 women who had not found an abnormality. Almost two-thirds

of those women indicating the presence of a breast abnormality were in the 25-44 age group. It is of particular interest to note that of the 58 women who discovered an abnormality upon examining their breasts only 41 were sufficiently aroused to consult their doctor. However, in evaluating the significance of these answers one must bear in mind the semantics of the word "abnormal" in this question. It seems safe to suggest that probably the meaning of the word "abnormal" was not similarly interpreted by all interrogees. Lack of self-confidence in self-examination may also account for the failure to discover or report so few actual abnormalities. The incidence of breast abnormalities in so-called "normal" breasts has been variously estimated to be between 5 and 35 per cent depending upon whether the examination has been clinical or pathological (4) (5). Perhaps those women who were uncertain about an abnormal finding visited their physician for confirmation or reassurance. Since most lesions were considered innocent these women probably forgot the matter or were reluctant to admit their finding of a doubtful abnormality.

"Have you had a breast examination, by a doctor, since seeing the film?"

In answer to this question 569 or 24.2 per cent of the 2,358 women interviewed indicated that they had had a breast examination by a doctor since seeing the film; the remaining three-fourths said they had not had a physician's examination. Women in the higher work grades, older ages, and higher academic levels indicated a greater frequency of breast examination by a doctor since seeing the film. There appeared to be no discernible difference between whites and non-whites. Only 14 per cent of the unmarried women had had a breast examination by a physician whereas 28 per cent of the married women were examined.

Despite the fact that only 58 women noted a breast abnormality during their own examina-

tion, yet 569 women went to their doctor for a more thorough examination of their breasts. This breast examination was either incidental to a general examination or made specifically for this purpose alone. Greater confidence in a professional examination as compared to self-examination may partly explain this situation. However, the differentiation of a "lump" from a "lumpy" breast is often a difficult matter and may be beyond the ability to distinguish on the part of many women who perform self-examination.

Cancer education is frequently held responsible for creating cancerphobia. Yet in the matter of cancer detection a provident fear may be the mother of early diagnosis and later salvation. A good idea can't be blamed for the folly of its followers. The fact that 569 women were examined by their doctor some time during the six month period since being exposed to the film—physician discussion experience reflects a real appreciation and willingness to profit from the recommended advice.

In those 569 women who were examined by their doctor the answers to the subordinate question, "What did the doctor say?" varied considerably. However, most of the women (81 per cent) were found by the physicians to have no significant breast abnormality and were thus reassured. Some evidence of breast disease was noted in 52 women or 8.8 per cent and, as indicated by the response to the next question, a much smaller number came to surgery. The other 10 per cent gave miscellaneous and varying types of answers.

"Have you had a breast operation since seeing the film?"

In the six month period between seeing the film and replying to this question, 15 women were operated upon for breast disease by a surgeon of their own choice. The pathologic diagnosis was carefully investigated and confirmed as benign in each case. It is of special interest to note that prior to seeing this film only 110

women had ever had a breast operation over a cumulative period of many years, whereas within the six month period, since seeing the film, 15 women had already undergone surgery. Cancer education, therefore, results in a situation that places an enormous responsibility upon the cancer detection diagnostic skill and vigilance of every practitioner. Biopsy and surgical excision of discrete and solitary breast tumors is certainly the treatment of choice, yet great care and caution must be exercised to prevent needless surgery.

In addition to these 15 women who were present for both the showing of the film and the follow-up interview, three women who saw the film, but were not available for the interview, were subsequently operated upon for breast cancer. It must be pointed out that the three cases mentioned represent a minimum number of such cases, since there was no knowledge of the status of some 500 to 600 others who saw the film but were not available for interview. These three women who saw the film, but were not interviewed, were subsequently operated upon for breast cancer and were unable to be present at the time of the interview because of convalescence (two cases) and death (one case). While these three women who saw the film were not interviewed, it is known that they discovered their cancer as a result of self-examination, and the data about them are deliberately included because of their great bearing on the subject. Furthermore, if biostatistics is "arithmetic guided by logic," then the virtue of this deliberate inclusion of selected cases would be acceptable in the minds of both clinicians and biostatisticians.

In evaluating the armor of cancer education and more specifically the film "Breast Self-Examination" and associated physician discussion technique, do the results justify the means? Is there danger of creating cancerphobia by this "self-examination" habit? In the light of this consideration it is of paramount importance to note that the expected incidence of breast

cancer in this entire group of women over a six month period would be only *one* case of cancer of the breast, whereas, the actual incidence of breast cancer was at least *three* cases of this malignancy—three times the predicted incidence. A statistical test was made and it was found that the difference was highly significant. This three-fold increase in incidence will perhaps be still greater in the future, for this group of women have been alerted to the problem and are continuing the self-examination practice. Self-examination discovers those small and presumably early cancers which cast their shadows before them. Thus, although breast self-examination is by no means a divining rod, yet by its routine practice women are finding today what would be obvious tomorrow.

"Have you told any member of your family or any of your friends to examine their own breasts?"

In answer to this question there were 1,406 women or 60 per cent who replied "yes" and there were 952 women or 40 per cent who replied "no." From the nature of the study it is impossible to measure the cumulative benefits of this type of secondary spread of information.

SUMMARY AND CONCLUSIONS

1. A group of 2,358 women were personally interviewed approximately six months after seeing the film, "Breast Self-Examination" and participating in an educational discussion with a physician, to evaluate the effectiveness of this form of cancer education. The color and age characteristics of this group approximated those of adult females in the large urban community in which they live. A close correlation existed in answer to specific questions designed to test the validity of the results.

2. Prior to seeing the film only 7.8 per cent of these women indicated that they examined their breasts, whereas since seeing the film 80.7 per cent of these women or 1900 examined their breasts occasionally or frequently. About 33 per cent of the 1900 women who practiced breast

self-examination did so on a regular monthly basis as recommended by the film.

3. Women with a previous history of breast disease were less responsive to the film than the group at large. Married women, non-white women, and women with highest educational attainment responded best to this health education technique. The largest difference was between white and non-white and more markedly in groups whose ages were under 25 and over 55. The largest significant response due to educational background was demonstrated in the improvement between high school and less than high school education.

4. Indoctrination in the principles and practice of self-examination was highest in early adult life and lowest later in life. At about the age of 55 when the frequency of breast cancer is maximum, there appeared to be less effectiveness of the technique as manifested by less interest in the health habit of self-examination.

5. The importance of early detection and regular examination as well as the technique of breast self-examination were the most valuable lessons learned by this group of women. Only about 6 per cent of the replies indicated learning's labor lost.

6. Fifty-eight women or 3 per cent of those who examined themselves discovered an abnormality upon examining their own breasts. However, 569 or 24 per cent of these women who were interviewed went to their doctor for a more thorough examination of their breasts.

7. Prior to the showing of the film only 110 of the 2,358 women in this group had ever had a breast operation. After the film, in the short period of six months, there were 15 women, upon examination by a physician, who were deemed to warrant operation. Fortunately pathological examination showed these to be benign.

8. At least three women who saw the film, but were not interviewed, were operated upon and cancer of the breast proven. This is three times greater than the expected incidence of breast

cancer for this group of women over this period of time.

9. In the treatment of breast cancer the concept of early diagnosis and surgical therapy is a sovereign precept which affords the highest hope of greatest benefit. The technique of showing the film "Breast Self-Examination" with associated physician-audience discussions is an effective method of teaching the public the principles of early detection by means of self-examination.

The authors acknowledge with thanks the assistance of Dr. Harry L. Chant and K. Ruth Seese.

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NEW SENATE LEGISLATION

Senate Bill 2759 AMENDS VOCATIONAL REHABILITATION ACT

AMA Washington Letter—No. 56

An Administration bill based on the President's health message to Congress. The bill would substitute for the existing Vocational Rehabilitation Act a new act authorizing appropriations to assist in the rehabilitation of handicapped persons in three ways: (1) Grants to states to meet the cost of rehabilitation services, (2) Six-year grants to states to extend and improve rehabilitation services, and (3) Grants to states and to public and other non-profit organizations and agencies to meet the cost of unique projects directed toward the solution of regional or national rehabilitation problems. During the fiscal years 1955 and 1956 special project grants would be available for helping the states to plan and initiate a substantial expansion of their vocational rehabilitation programs.

The bill is not intended to provide grants for major new construction.

Each state would have a minimum allotment for general grants of \$50,000 with the federal share varying from 33 $\frac{1}{3}$ % to 66 $\frac{2}{3}$ %.

Extension and improvement grants would carry a minimum allotment of \$5,000 per state with the federal share up to 75% of the cost for the first two years, 50% for the next two, and 25% for the last two years.

Payments under the unique project grants would be determined by the Secretary of Health, Education, and Welfare. To receive federal approval of a plan, a state would designate a single administering agency and provide for personnel and administration standards to be approved by the Secretary of HEW. The state agency would agree to cooperate with the Bureau of Old-Age and Survivors Insurance, the state agency administering the state's public assistance program, and other bureaus providing vocational rehabilitation services.

Because of the new allotment and matching formulas, there would be a limit of 10% for any decrease in allotments to a state in any one year.

These amendments would become effective July 1, 1954. To Labor and Public Welfare Committee.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

At the annual election of the Medical Staff of the Cumberland Hospitals, the following physicians were elected to office:

Sacred Heart Hospital

President: DR. JAMES T. JOHNSON, JR.

Vice-President: DR. LEWIS BRINGS

Secretary: DR. JAMES P. HALLINAN

Memorial Hospital

President: DR. DONALD B. GROVE

Vice-President: DR. H. W. ELIASON

Secretary-Treasurer: DR. FRANK T. CAWLEY

BALTIMORE CITY MEDICAL SOCIETY COMMITTEES

CONRAD ACTON, M.D., *Journal Representative*

Dr Lewis P. Gundry, the President, has appointed the following Committees for 1954:

ADVISORY COUNCIL TO THE WOMAN'S AUXILIARY:

J. Arthur York, Chairman, Newland E. Day, Edward S. Johnson, J. Frank Supplee, III.

CONSTITUTION AND BY-LAWS COMMITTEE:

Moses Paulson, Chairman, Marius P. Johnson, Lawrence R. Wharton.

COMMITTEE ON EMERGENCY MEDICAL CALLS:

Paul E. Carliner, Chairman, James D. Carr, Joseph F. Drenga, Clewell Howell, Walter E. Karigin, Lauriston L. Keown, Louis F. Klimes, Nathan Racusin, C. Arthur Rossberg, Aaron C. Sollod.

COMMITTEE ON GERIATRICS:

Herman Seidel, Chairman, Perry Futterman, Robert L. Jackson, Harry F. Klinefelter, Jr., Louis Krause, Robert E. Reiter.

LEGISLATIVE COMMITTEE:

Daniel J. Pessagno, Chairman, Raymond F. Helfrich, James P. Miller, Eduard Novak.

JOINT COMMITTEE ON MATERNAL MORTALITY:

Huntington Williams, Chairman, George H. Davis, D. McClelland Dixon, Louis H. Douglass, Nicholson J. Eastman, W. Drummond Eaton, John M. Haws, Hugh B. McNally, John E. Savage, Isadore A. Siegel, Matthew L. Taback.

MEMBERSHIP COMMITTEE:

William L. Garlick, Chairman, Maurice L. Adams, Joseph S. Ardinger, Jr., James G. Arnold, Dudley C. Babb, Benjamin M. Baker, Jr., Daniel E. Bogorad, Harry C. Bowie, Thomas S. Bowyer, Charles B. Brack, Charles E. Carr, Jr., Dwight M. Currie, Walter E. Dandy, Jr., Garrett E. Deane, John S. Eastland, Samuel L. Fox, Charles R. Goldsborough, S. Butler Grimes, Rachel K. Gundry, Louis P. Hamburger, Jr., Richard P. Hanchett, Robert W. Johnson, III, John M. Scott, Henry F. Ullrich.

POSTGRADUATE COMMITTEE:

Harry M. Robinson, Jr., Chairman, Samuel P. Asper, Henry T. Bahnson, Howard M. Bubert, C. Lockard Conley, J. L. Lilienthal, Ross L. McLean, Samuel Whitehouse, Wetherbee Fort, ex officio.

PUBLICITY COMMITTEE:

James R. Karns, Chairman, Conrad Acton, Barbara J. Betz, Ernest C. Brown, Jr., Ernest I. Cornbrooks, Jr., James D. Lockard, Harry M. Robinson, Jr.

COMMITTEE ON PUBLIC MEDICAL EDUCATION:

H. Hanford Hopkins, Chairman, Houston S. Everett, Whitmer B. Firor, Amos R. Koontz, Harry M. Robinson, Jr.

There are still a few committees to be appointed and they will be published in a later issue of the Journal.

The Postgraduate Courses have had a most auspicious start. At the first meeting more than sixty doctors attended. These courses interposed in the middle of the working day shows the interest that has been aroused. The continuing of professional education in our postgraduate years should be of growing concern to all of us. The burgeoning attendance at our meetings and these Courses make a very healthy index.

Our January meeting was very well attended and the program of "outside" experience in Tuberculosis gave perspective and fresh viewpoints. The Annual Meeting of the Faculty will be imminent when this

goes to press. We all wish the Auxiliary great success with its second annual Ball.

BALTIMORE COUNTY MEDICAL ASSOCIATION

SAMUEL P. SCALIA, M.D.

Journal Representative

The January luncheon meeting of the Baltimore County Medical Association was held at the Stafford Hotel on Wednesday, January 20, 1954.

The new officers and committee chairmen were introduced to the membership.

President, Martin E. Strobel; *Vice-President*, Thomas E. Wheeler; *Secretary and Treasurer*, Clarence E. McWilliams, Jr.; *Delegates and Alternates to the Medical-Chirurgical Faculty of Maryland*: Charles F. O'Donnell (*alt.*), Clewell Howell, Melvin B. Davis (*alt.*), David H. Andrew, George S. M. Kieffer (*alt.*), Samuel P. Scalia; *Legal Counsel*, William D. Wells; *Board of Governors*, Present Officers and Delegates, Past President:—Charles F. O'Donnell, William H. F. Warthen; *Board of Censors and Medical Ethics*, Charles F. O'Donnell, Charles H. Williams; *Medical Legislation*, Charles H. Williams; *Historical Committee*, Edward H. Benson; *Medical Economics*, George E. Urban; *Investment of Funds*, George S. M. Kieffer; *Hospital Committee*, Wilmer H. Gallagher; *Public Relations and Journal Representative*, Samuel P. Scalia; *Publicity*, William H. F. Warthen; *Constitution and By-Laws*, William R. Dunton, Jr.; *American Medical Education Fund*, Paul H. Royse; *Emergency Medical Service*, Louis Dalmau.

It was announced by Dr. Strobel that the board of Governors had met on January 16, 1954 to discuss the proposed preliminary trial of Poliomyelitis vaccine. It was explained to the board by Dr. Edward Davens of the State Department of Health that this vaccine is definitely not the answer to the poliomyelitis problem and that a good deal of public-health education is necessary. The various organizations interested in this disease have been somewhat overzealous in their issuance of reports to the public. The preventive vaccine is not here and the proposed field trial is but a mass experiment. The vaccine has protected animals, but its use in humans has been very limited.

The directory of the Baltimore County Medical

Association was very successful in its first issue in 1953. A new edition is being prepared for 1954. All county practitioners are urged to contact Dr. Clewell Howell or Dr. Charles F. O'Donnell if they are not already listed in the 1953 directory.

The Baltimore County Health Department is conducting a survey of fatal home accidents. The cooperation of county physicians is being solicited. At the time of a fatal accident, a telephone call to the Health Department in Towson will suffice for a complete investigation.

As is customary, the outgoing president gave a short talk at the January meeting. Dr. O'Donnell brought out the fact that the Baltimore County Medical Association is now an integral part of health affairs in the county. The County Health Department confers with our society and this has made for better cooperation as concerns health matters in the county. This is important for it makes the organization the standard bearer of medicine in the county. Dr. O'Donnell also discussed the role of the county Medical Society in regard to Medical Care. The county plan is running quite smoothly and the county practitioners are to be thanked for their cooperation.

CARROLL COUNTY MEDICAL SOCIETY

WILLIAM L. STEWART, M.D.

Journal Representative

Two new members were received into the Society—Dr. Bertrand C. R. Gau, formerly of France and Dr. Howard Hall of Baltimore. Both doctors have recently established practices in Sykesville.

Officers for the coming year are: *President*, William Culwell; *Vice-President*, R. S. McVaugh; *Secretary and Treasurer*, William L. Stewart.

Dr. A. M. Powell of Frederick County, gave a very interesting and educational talk on "Therapeutic Poisons" as they are encountered in pediatrics when the Society met at Hoffman's Inn, Westminster.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

BENJAMIN S. MILLER, M.D.

Journal Representative

Dr. Samuel Sugar, Chairman of the Diabetes Detection Drive for Prince George's County, reported

a very successful campaign. Approximately 1600 tests were performed, of which 1350 were on students in the secondary schools. There were 91 positive results (two on known diabetics). This represents 89 potential new cases which were referred for evaluation to their family physicians. The Board of Education and two local chapters of the National Council of Jewish Women rendered outstanding aid in collecting specimens and conducting the tests.

At the January meeting of the Society, Dr. Norman Comeau spoke on "Sub-acute Thyroiditis." One of the cases reported represented the second case of this disease to be treated with cortisone.

WASHINGTON COUNTY MEDICAL SOCIETY

SIDNEY NOVENSTEIN, M.D.

Journal Representative

A winter meeting of the Washington County Medical Society was held at the Alexander Hotel with Dr. I. L. Houghton, retiring President, presiding.

New officers installed for 1954 were: *President*, Dr. Archie Robert Cohen; *Vice-President*, Dr. S. Earl Young; *Secretary-Treasurer*, Dr. Ernest F. Poole.

The question of public relations was discussed with reference to various articles in magazines and papers. Some of these articles were very critical of the medical profession. It was voted to approve the appointment of a public relations committee to take care of such adverse publications in the press.

The April meeting is to be devoted to the general

topic of public relations, the human side and the business side of medicine.

Dr. W. T. Layman is to represent the Society at the regional meeting wherein proposed legislation of the Eighty-third Congress is to be discussed.

Dr. Ross Cameron, Health Officer of Washington County spoke on the Medical Care Program, stating that he felt the Medical Care Program of Maryland is the answer to socialized medicine. The Advisory Committee of the Medical Care Program was invited to a meeting in Baltimore, January 19, 1954, at the request of the State Health Department.

Dr. David R. Brewer was the representative of the Washington County Medical Society at the regular meeting held in Washington, November 15, 1953, in reference to veteran medical care. The Society approved the request of the State Society that the three Veterans' Hospitals in Maryland be surveyed as to the percentage of service connected cases to non-service connected cases.

WICOMICO COUNTY MEDICAL SOCIETY

WILBER R. ELLIS, M.D.

Journal Representative

At the November 9th meeting of the Wicomico County Medical Society we were pleased to have as guest speaker Dr. Charles P. Bailey of the Bailey Thoracic Clinic in Philadelphia, who gave a most interesting talk on "Cardiac Surgery."

With us on December 14th was Dr. Byrd Leavell, Assistant Professor of Medicine, University of Virginia, who spoke on "Treatment of Anemias."

ON BEHALF OF ALLIED HEALTH PERSONNEL

AMA Special Report, No. 16

Quoted from a Statement of the American Medical Association To the Committee on Interstate and Foreign Commerce House of Representatives by Walter B. Martin, M.D.

Our most urgent effort should be directed to the solution of the problem of the medically indigent and the chronically ill. We believe that this objective can be reached without major change in our existing mechanism.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

MENINGITIS

LOUIS KRAUSE, M.D.*

Undoubtedly this disease is extremely ancient even though our literary remains fail to identify it as such. One of the fascinating references to the possible occurrence of a septic meningitis is found in the ancient Edwin Smith Egyptian surgical papyrus in which the attitudes of a patient are described. The fact was detailed that when the head is drawn backwards and held rigid, and the back becomes arched, the patient then must be kept at his "mooring post," the latter term meaning expectant treatment. It also relates that the condition may follow an injury to the head. Certainly this is a rather clear description of a meningitis secondary to a fractured skull, particularly of the base of the skull.

Throughout history, we have descriptions of symptoms that would suggest the possibility of meningitis. However, it is only recently that this entity has been clearly identified as we know it today. Such early terms as "spotted fever" because of the frequency of petechiae and "brain fever" because of the cranial symptoms, were generally used instead of the modern term of meningitis. With the advent of the bacteriological age, specific etiologic agents were identified and the clinical pictures of the various types of meningitis were readily supplied. This occurred at the turn of this century.

At first, therapy was directed entirely to the symptoms, and later to the mechanical changes in an attempt to reduce the intra-cranial pressure. Anti-sera were used. Today the antibiotics have been found to be very effective. Previously, in most instances, it was a devastating and fatal disease. Frequently those who survived became hopeless invalids, physically and mentally.

Today the picture has been entirely changed. Many times the disease is stopped in its tracks during its onset. The following list of books portray the

history, course, and effectiveness of present day therapy.

BOOKS ON MENINGITIS IN THE MEDICAL AND CHIRURGICAL FACULTY LIBRARY

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* Chairman, Library Committee.

FIFTY YEARS AGO IN MARYLAND MEDICINE

Recently in connection with a research project in our library, we had occasion to consult the "Maryland Medical Journal" of 1904. We were fascinated by some of the material and, as this journal was the spiritual ancestor of the "Maryland State Medical Journal," we thought perhaps some of today's readers might be interested.

The big news at the beginning of the year was the Tuberculosis Exposition. The preliminary announcement reads:

"The Tuberculosis Exposition will open on January 25 at McCoy Hall. The opening meeting will be held at 8 o'clock on Monday evening. Prominent officials of the State and of the city will be present, including Governor Warfield and Mayor McLane. The orator of the evening will be Dr. E. L. Trudeau of Saranac, N. Y. At five o'clock each afternoon after Monday there will be lectures upon the various aspects of the tuberculosis problem. . . . The exposition is organized under the joint auspices of the Tuberculosis Commission, the State Board of Health, and the Maryland Public Health Association. These have called to their aid a large general committee of 250 leading citizens. . . . the chairman, Dr. Henry Barton Jacobs."

Included in the executive committee were many names well-known in local medical history, among them Dr. W. G. MacCallum, Dr. William H. Welch, Dr. William Royal Stokes, Dr. Standish McCleary, Dr. S. J. Fort, Dr. Mary Sherwood, Miss Adelaide Nutting, and Dr. William Osler.

That the Exposition was a great success is shown in the issue of March 1904 which states:

"The Maryland Tuberculosis Exposition received the unstinted praise of discriminating observers from all parts of this country, and appears to have been duly appreciated inside the family circle of the State. Of those who watched the preparations no one doubted that the Exposition would reward the in-

terest of physicians and special students of tuberculosis, but many doubted whether its especial message would be effectively lodged in the public mind. When, within two days, the people had paid to the Exposition the amplest tribute of interest, its sponsors were gratified beyond measure. Even the most enthusiastic among them had not expected such success.

"... The Exposition demonstrated that it is both expedient and practicable to admit the general public to free participation in the scientific knowledge of tuberculosis, and the demonstration is highly important in a country where all reforms wait upon public opinion. It did not appear in this experiment that the education of the public is either difficult or dangerous."

February, of course, was the month of the Baltimore Fire and the editor of the "Maryland Medical Journal" has an editorial in the March issue which is something of a reproach today. We quote, in part,

"In the experience of a life-time hardly anything can be more impressive than the history of Baltimore in February 1904. A bewildering spectacle, an appalling disaster, and a magnificent opportunity were offered to us in the space of sixty hours. We accepted the opportunity with great enthusiasm and speedily convinced the world that a model city would arise upon the devastated area."

In the "medical items," the following note concerning the fire appears:

"One result of the fire has been an increased number of patients in the various hospitals, amounting in some instances to overcrowding. The amount of sickness is but slightly in excess of that which is usual at this season, but the number of persons seeking hospital treatment is largely increased."

A personal item of interest is the following:

"Dr. Hiram Woods is recovering from the serious accident which befell him in the collision of his carriage with a runaway team in Druid Hill Park."

M.E.B.

Health Departments

MARYLAND STATE DEPARTMENT OF HEALTH

Statement of the State Board of Health Regarding the Aims of the Proposed Preliminary Trial of Poliomyelitis Vaccine

In view of the increasing volume of publicity which has accompanied the proposed poliomyelitis vaccine field trial, the State Board of Health at its monthly meeting on January 15, 1954 expressed its concern that the real nature and purpose of this study shall not be obscured by wishful thinking. Some of the statements which have already appeared seem to have originated more from the imaginations of the overzealous than from the scientific facts at hand.

It should be clearly understood that as yet there is no scientific proof that this vaccine is effective in preventing polio in humans.

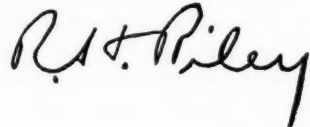
Medical history has clearly shown that important scientific advances have always come only after patient, painstaking, and objective work which is carried out with the utmost precautions to insure the accuracy of the study and the safety of the patient. There is no place in a study such as this for the overzealous enthusiast or the wishful thinker who jumps to the conclusion that a preventive vaccine is already here. In the words of Dr. Jonas Salk, the scientist who developed the vaccine which is now under study, "we do not want to allow any distortion of the fact that we are still actively in the stage of clinical investigation; and that this work must be continued, but it must be continued gradually and cautiously."

The State Board of Health and the public want, desperately want, to have an effective preventive vaccine available. The point is that if we are to achieve this happy goal we must be sensible and be guided by the most expert medical opinion available. The following statement has been prepared by outstanding poliomyelitis experts and represents the position of the State Board of Health at this time. It is planned that the statement will be revised when the scientific facts accumulated warrant such change.

For some years it has been apparent that the best hope for the control of polio lies in vaccination with the virus itself. More recently it has become clear that protection from paralysis can be produced in experimental animals by vaccines containing virus inactivated by chemicals—that is, virus incapable of causing disease. Preliminary trials of such vaccines in human beings indicate that they are harmless and that they produce immune responses which *should be* adequate to ward off paralysis. The proposed trials of vaccine are aimed at showing whether or not this is actually the case.

Paralytic polio is a relatively rare event even during epidemic times. For example, a severe epidemic of polio may strike down only one child in a thousand under ten years of age. This means that extensive trials in many thousands of children will be required before the protective power of a vaccine can be accurately determined.

Present supplies of vaccine probably do not allow of trials extensive enough to furnish a completely conclusive answer this year, but it is felt that the amounts which will be available this spring may give suggestive answers and will indicate the important lines to follow next year.



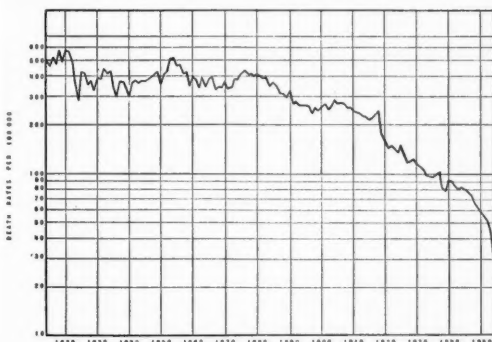
Director

BALTIMORE CITY HEALTH DEPARTMENT

Phenomenal Decline in Tuberculosis— 1953

A truly phenomenal decline of 31 per cent in Baltimore's tuberculosis death rate and an even more striking drop of 45 per cent in the city's Negro tuberculosis death rate compared with 1952 are the most prominent features in the vital statistics for 1953. With these health advances, tuberculosis for the first time in the medical history of the city drops out from the ranks of the "major killers."

From the very beginning of medical statistics pertaining to causes of death in Baltimore City, tuberculosis has ranked among the major killers. The earliest rate recorded, in 1812-1815, indicates that 525 persons per 100,000 died annually from tuberculosis. Following a variable course this rate dropped to 414, recorded in the period 1876-1880. From this point, tuberculosis has been slowly but steadily falling. In 1900 the mortality rate was 239; in 1920 it was 151; in 1930 the death rate from tuberculosis had declined to 115. The trend and rate of decline of tuberculosis mortality are shown in the following graph and table.



Tuberculosis Death Rates per 100,000 Population, Baltimore 1814-1953

DEATH RATES FROM TUBERCULOSIS (ALL FORMS)
BY RACE: BALTIMORE CITY 1940-1953

Year	Deaths per 100,000 population			Annual Percentage Change		
	Total	White	Colored	Total	White	Colored
1953	30.0*	19.0*	57.0*	-31	-21	-45
1952	43.5	24.0	104.1	-17	-18	-8
1951	52.1	29.3	123.9	-8	-10	-6
1950	56.4	32.5	132.6	-10	-4	-17
1949	63.0	33.8	159.8	-7	-12	-5
1948	67.8	38.3	168.2	-9	-4	-14
1947	74.5	39.9	196.0	-4	-11	0
1946	77.8	44.9	196.5	-4	0	-9
1945	80.9	44.8	215.0	-3	-3	-4
1944	83.1	46.4	223.7	+2	-6	+8
1943	81.1	49.2	207.7	-4	+5	-13
1942	84.2	46.7	240.1	-8	-3	-12
1941	91.2	47.9	271.4	-1	-10	+7
1940	92.1	53.2	253.0			

* Provisional rates.

From the table it is clear that there is no decline of more than 18 per cent compared with a prior year until 1953 when the white decline was 21 per cent and the nonwhite a precipitous 45 per cent.

The long time trend of decline has a variable interpretation. It is probable that the following factors have been important: Natural selection, by which is meant the process whereby those persons susceptible to tuberculosis have not reproduced to the same extent as persons resistant to the disease; improved standards of living and better habits of personal hygiene, together with an extension of better housing and a higher nutritional level to an ever widening segment of the population; and the effort of the Health Department in the control of tuberculosis by isolation of tuberculous persons as soon as possible after discovery and by careful observation and instruction of the contacts of such individuals. The recent acceleration in the decline of tuberculosis mortality is believed to be cumulative and also primarily due to the effectiveness of streptomycin and other related drugs. An analysis of newly reported Negro cases of tuberculosis in the last half of 1952 who were treated at home with streptomycin under supervision by the Bureau of Tuberculosis indicates that such patients have experienced a 47 per cent reduction in fatality rate as compared with a similar series of cases reported late in 1951 when the home treatment program had not yet begun.

Although the mortality from tuberculosis shows striking declines, the annual incidence of cases has remained fairly constant at about 1,400 for the past five years. This would appear to be somewhat unexpected in the face of the mortality trend except for the widespread use of mass X-ray surveys.

Huntington Williams, M.D.

Commissioner of Health

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, January 29-February 25, 1954

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County.....	65	1	3	4	158	—	84	—	—	—	32	—	—	3	20	—	7	—	5
Anne Arundel.....	21	—	—	4	24	2	18	1	—	—	2	—	—	—	5	—	4	—	10
Howard.....	1	—	—	—	9	1	5	—	—	—	1	—	—	1	1	—	1	—	—
Harford.....	15	—	1	32	1	—	25	—	—	—	19	—	—	13	4	—	—	—	5
Carroll.....	1	—	1	2	81	—	3	—	—	—	5	—	—	—	3	—	—	—	1
Frederick.....	—	—	—	10	3	1	—	—	—	—	2	—	—	—	9	—	1	—	4
Washington.....	10	—	—	13	—	1	16	—	—	—	—	—	—	5	7	—	1	—	2
Allegany.....	5	—	—	3	—	—	20	—	—	—	3	—	—	2	3	—	—	—	3
Garrett.....	—	—	—	14	1	—	—	—	—	—	18	—	—	—	—	—	—	—	1
Montgomery.....	24	1	1	6	12	—	62	—	—	—	18	—	—	2	8	—	—	—	2
Prince George's.....	14	—	3	—	6	—	7	—	—	—	23	—	—	3	6	2	e-1	—	1
Calvert.....	2	—	—	3	—	—	—	—	—	—	—	—	—	1	1	—	1	—	—
Charles.....	1	—	—	3	3	—	1	—	—	—	—	—	—	—	2	—	c-1	—	—
Saint Mary's.....	—	—	—	8	2	—	1	—	—	—	6	—	—	—	1	1	1	—	1
Cecil.....	—	—	—	14	—	—	—	—	—	—	1	—	—	—	1	—	—	—	1
Kent.....	10	—	1	—	6	—	11	—	—	—	—	—	—	—	—	—	1	—	—
Queen Anne's.....	1	—	—	—	2	—	1	—	—	—	—	—	—	—	1	—	—	—	—
Caroline.....	—	—	—	—	3	—	—	—	—	—	1	—	—	1	2	—	—	—	—
Talbot.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	2	—	—
Dorchester.....	2	—	—	—	10	—	—	—	—	—	—	—	—	—	—	—	10	—	2
Wicomico.....	7	—	2	1	65	—	2	—	—	—	—	—	—	2	—	1	14	—	3
Worcester.....	—	—	—	4	61	—	3	—	—	—	—	—	—	—	3	—	4	—	1
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	2
Total Counties.....	179	2	12	121	447	5	259	1	0	0	131	0	0	33	79	4	49	—	44
Baltimore City.....	374	2	25	10	999	1	142	0	0	0	99	0	0	47	116	16	433	—	27
State																			
Jan. 29-Feb. 25, 1954...	553	4	37	131	1446	6	401	1	0	0	230	0	0	80	195	20	482	—	71
Same period 1953.....	491	5	134	51	55	19	126	0	0	0	319	2	1	21	166	13	557	—	181
5-year median.....	491	5	69	—	710	7	158	1	—	0	154	1	2	41	202	43	533	—	71
Cumulative totals																			
State																			
Year 1954 to date.....	1167	4	53	218	2137	10	772	2	0	0	349	2	0	169	311	38	1121	—	132
Same period 1953.....	1042	6	183	87	133	27	234	1	0	0	530	2	2	44	407	25	1244	—	267
5-year median.....	866	11	97	—	1250	14	282	3	—	0	283	3	6	93	383	81	1073	—	131

c = congenital syphilis under 1 year.

e = infectious encephalitis.



Blue Cross - Blue Shield



BLUE CROSS IN 1953—A PROGRESS REPORT

R. H. DABNEY*

In November 1937, twelve public-spirited men set in operation a "bridge to health" which, in the course of just one year, spanned the financial chasm between fifteen Baltimore hospitals and 32,000 citizens of the community. Since that time, the traffic of people going to hospitals has multiplied so rapidly that in total, Maryland Hospital Service (Blue Cross) has paid out \$54,300,000 to provide hospital services for the people of Maryland.

Today, sixteen years later, the bridge is stronger and better able to bear the weight of the heavier traffic. Against a background of increasing population within the State and steadily rising costs of hospital care, Maryland Blue Cross has grown from a modest blueprint to a major community institution embracing all of the forty voluntary general hospitals in the State and 869,000 of its citizens. In 1953 alone, the total payments to hospitals amounted to \$11,360,000 for the 124,000 Blue Cross members who needed hospital care.

The "bridge to health" is suspended on three main supports, namely; (1) membership growth, which means community acceptance, (2) utilization, or the rate at which members go to hospitals, and (3) the financial situation. Each support must withstand the stress and strain of changing conditions, and must always be strong enough to carry the basic Blue Cross objectives of service to the community at the lowest possible cost. This report for 1953 will give you a picture of the strength of Blue Cross in Maryland today.

Membership

In 1953, one out of every three persons in Maryland was a Blue Cross member. Although the net increase in membership was not as great as in pre-

vious years, this year's final total of 869,000 members represents an increase of approximately 9,000 throughout the State—and is a new record high. In Maryland, 43.9 per cent of the population (excluding areas suburban to Washington) are now enrolled, as compared to a national average of 28.4 per cent. Blue Cross membership in Maryland continued to rise in 1953, but the rate of growth slowed down due in part to the ever-increasing commercial competition in the field.

Blue Cross Enrollment

1938—First Year	32,454
1946—Postwar Year	441,284
1953—Current Year	868,775

Utilization

Blue Cross is proud of the service it renders to the community, and the extent of that service can best be judged by the number of members who went to the hospital, the length of time they stayed, and the payment made. In 1953, more subscribers were hospitalized than in any other year—124,375, as compared to 110,000 in the previous year. The average in-patient stay was 7.24 days (slightly down from 7.30 days in 1952), and the average payment per case rose to \$125.65, as compared to \$118.85 in 1952.

1952		1953
109,958	Subscribers Hospitalized	124,375
643,364	Days of Care (In-Patient)	671,390
\$118.85	Average Payment Per Case (In-Patient)	\$125.65
\$10,257,270	Total Hospital Payments	\$11,360,495

Financial Strength

A sound financial condition lies at the base of membership and utilization. In 1953, subscription income—boosted by a rate increase in the early part of the year—rose to an all-time high of \$13,217,050, a 26% increase over last year. But at the same time, hospital costs continued to rise and more and more patients entered hospitals.

After two years of deficit operations when reserves had to be tapped to make ends meet, Blue Cross

* Executive Director, Maryland Hospital Service, Inc., Maryland Medical Service, Inc.

crossed over onto the black side of the ledger in 1953.

1952	Disposition of income	1953
97.0%	Hospital Care	85.1%
7.3%	Operating Expenses	6.0%
-4.3%	Subscriber Reserves	8.9%
100.0%		100.0%

Significantly, operating expenses continued to go down, as they have been doing for the last eight

years. Subscriber reserves were increased, and as of December 31st they were sufficient to provide for 4.13 months of hospital care at the present average rate.

The continued success of Blue Cross attests to the fact that it fills a real community need—and serves as a “bridge to health” for thousands of Marylanders. Blue Cross will continue to prosper with the sympathetic and enthusiastic support of the public, the hospitals, and the medical profession.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service, Washington 25, D. C.

The Sixth Annual Symposium on Recent Advances in the Study of Venereal Diseases will be held in the auditorium of the Department of Health, Education, and Welfare, Washington, D. C., on April 29 and 30, 1954, it was announced today by Dr. James K. Shafer, Chief of the Public Health Service's Division of Venereal Disease.

The sessions are open to all physicians and workers in allied professions, who are interested in participating. These symposia usually draw hundreds from all parts of the country and are the occasion for exchange of the latest available information by some of the outstanding authorities in the field of venereal disease.

The topics that will be discussed at this symposium will cover many aspects of venereal disease control including basic and clinical research, serology, epidemiology, treatment, program operation, and professional education.

ON BEHALF OF BETTER DOCTOR DISTRIBUTION

AMA Special Report No. 16

Quoted from a Statement of the American Medical Association To the Committee on Interstate and Foreign Commerce House of Representatives by Walter B. Martin, M.D.

Because many problems of so-called doctor shortage are in reality problems related to physician mal-distribution, the American Medical Association has established a placement bureau to serve as a clearing house for information in answer to requests from physicians seeking a location and from communities seeking a physician. Placement programs are now in active operation in at least 37 states and at least 32 are sponsored by state medical societies. A. M. A. is sponsoring rural health conferences and programs and preparing literature to help communities attract physicians in an effort to stimulate public as well as medical efforts to bring doctors into needed areas.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. CHARLES H. WILLIAMS, *Auxiliary Editor*

FOREWARNED IS FOREARMED

MRS. R. WALTER GRAHAM, Jr.

All thinking people since the time of the Revolutionary War have agreed that our country should be responsible for its soldiers injured in battle. In recent years, however, this policy has been relaxed to the extent that now almost 85% of the patients cared for in V. A. hospitals are being treated for injuries or diseases that have no connection whatever with war. Moreover, a large proportion of these patients could pay for treatment in private hospitals. Instead, they have signed a pauper's oath declaring that they are indigent. Since no effort has been made to prove the validity of such statements, the abuse has become increasingly widespread.

As of August 31, 1953 there were more than 20,000,000 veterans in an overall population of 160,000,000 people. Approximately 80,000 more are being added each month. By 1970 over 86% of all living veterans will be forty-five years old or over and 2,000,000 will be sixty-five or over. This means more and longer illnesses increasing the length of stay, costs and personnel requirements in the hospitals. Already the average stay in V. A. hospitals is thirty days compared to seven and a half days for a patient with similar disabilities in a civilian hospital.

The Nation's physicians view this prospect with concern. They question the end results of such a tremendous program; is it a proper charge on the remainder of the population, will it bring the best medical care to the veteran and will it undermine the civilian hospital program of the Nation?

On July 31st 1952 the V. A. operated 154 hospitals, an increase of 25 in three years. These 154 hospitals operate 116,986 beds. In 1952 the V. A. was constructing 18 new hospitals and four additions with a total of 13,231 beds. In the planning stage are six new hospitals with 5,000 beds. The V. A. now maintains *three* times the number of beds needed for treatment of service-connected cases. Of

22,613 veterans awaiting admittance as of June 30th, 1953, only *three* had service-connected disabilities.

Many medical authorities are convinced that the V. A. cannot attract personnel to staff more than 120,000 hospital beds, although it is proceeding with a program providing more than 152,000 beds. This is creating an artificial shortage of doctors and other health personnel through its duplication of hospital facilities. There will not be an adequate number to staff both the expanding V. A. and civilian hospital programs. The Federal Government duplicates facilities by providing funds for hospital construction for two classes of citizens—for civilians through the Hill-Burton Act, and for veterans through V. A. The end result of this duplication is that government hospitals compete with civilian hospitals for personnel and for non-service-connected patients who should be treated in civilian hospitals. It is becoming increasingly difficult for civilian hospitals to operate at a reasonable cost because of this funneling off of both personnel and patients. This conflict is causing a continual increase in the cost of hospital and medical care for persons who must pay their own way.

The A. M. A. feels that the Hill-Burton Act improves the availability of hospital care for the entire population at less cost to the taxpayer. The A. M. A. believes also that Congress should decide:

1. Whether existing legislation providing care for veterans with non-service-connected disabilities is sound.
2. Whether the Federal Government should continue to engage in a gigantic medical care program in competition with state, local and private institutions.
3. Whether the ever-increasing cost of such a program is a proper burden to impose on the taxpayers of this country.

Since the A. M. A. has stated its position clearly and unequivocally, it is proper that the women of the Medical Auxiliaries should watch the trend and be prepared to back up their husbands. Should the need arise, be organized and ready to help.

TENTH ANNUAL CONFERENCE*

MRS. ALBERT E. GOLDSTEIN

The conference was held at the LaSalle Hotel, Chicago, Illinois, November 18, 19 & 20, 1953.

Registration opened at 9 a.m. and Mrs. Leo Schaffer, National President, called the meeting to order at 10 a.m.

After the invocation, pledge of loyalty, welcome and introduction, at which time our own Mrs. George Yeager, Constitutional Secretary, was introduced, Mrs. George Turner, President-elect, was presented and conducted the conference.

Following the roll call at which time the President and President-elect of Maryland responded, the chairman asked the president to give her report. Mrs. Schaffer talked on "The Health Education Project" and the work that lay ahead of us and used the slogan, "Together We Progress."

She mentioned 170,000 physicians living in the United States—90,000 of them bachelors—and just 60,000 Auxiliary members. She warned us to get busy. We were told to look for startling information from the National Foundation concerning Polio. The trial vaccine and gamma globulin inoculations are advancing research so rapidly that a third of the March of Dimes receipts will be contributed to Polio Prevention Program.

She talked on the Crusade for Freedom, with its three strong arms:

1. The American National Committee for a free Europe.
2. Radio Free Europe.
3. The American People (demonstrating that the way of free man is best).

Be an alert citizen.

Learn all you can about the menace of Soviet Imperialism and support the Crusade for Freedom.

The National Convention date was announced June 21 to 25, 1953, at Fairmount Hotel, San Francisco.

The speaker closed her talk with a line from Longfellow's Psalm of Life and symbolized it when

* The report of the Tenth Annual Conference for State Presidents, Presidents-Elect and National Committee Chairman of the Woman's Auxiliary to the American Medical Association.

she said, "He who would leave footprints on the sands of time must wear work shoes."

Dr. Ernest Howard, Assistant Secretary of the A. M. A., addressed the conference on the Veterans' Medical Care Program.

The A. M. A. House of Delegates, June 1953, recommended:

1. Congress enact legislation limiting V. A. Medical care and hospitalization benefits to veterans with peace-time and war-time services whose disabilities or diseases are service-incurred or aggravated.

2. Service to veterans with war-time service suffering from Tuberculosis or Psychiatric disorders of non-service-connected origin who are unable to defray the expense of hospitalization.

A total of 104,279 patients were in V. A. hospitals in June 1953; 65% of these patients were receiving medical care of illnesses or accidents incurred in civilian life following military discharge.

In a survey of 500 patients picked at random being treated for non-service-connected ailments in V. A. hospitals, 366 had annual incomes of from \$4,000 to \$50,000.

PROGRAM AND PUBLIC RELATIONS

The first panel on Wednesday's Program correlated with Public Relations. Mr. Leo Brown, director of Public Relations of the A. M. A., talked on Public Relations seasoning. He spoke of two types of public relations:

Internal—Relations with one another.

External—Relations with general public.

Contacting other organizations as hospital auxiliaries and other groups such as P.T.A. was stressed.

In some communities

1. Medical students' wives were organized.

2. Contact with the aged.

3. Collection of sample drugs and used instruments for medical and surgical relief committee.

All of these projects are basic tools for good public relations.

THE A. M. E. F.

The American Medical Education Foundation panel had Mr. Hiram Jones as the speaker. He felt the best public relations project of the Auxiliary was the A. M. E. F. He suggested that State Chairman of Auxiliaries should handle all checks, and money

should be sent in at intervals. The seventy-five approved medical schools turn out 6000 doctors a year. Last year forty-two state Auxiliaries contributed \$22,632.

Some means of fund raising for A. M. E. F. were:

1. Subscriptions to magazines
2. Memorial cards
3. Fashion shows
4. Coffee & Donut Breakfast \$1.00.

The speaker advocated the Hill-Burton Act which encourages communities through mutual appropriations to meet their own hospital needs. Two million dollars are expected from the medical profession this year and eight million is hoped for from industries.

LEGISLATURE

Mrs. Quayle of Washington, D. C. was chairman of the panel.

Mr. Joseph Stetler talked on the Legislative Program of A. M. A. for 1954.

Some bills we were asked to support were:

1. The Bricker Amendment opposing international treaties.
 2. Tax legislation which would enable doctors to deduct for graduate study.
 3. The Pension Plan allowing each individual doctor to put aside \$7500 a year tax free.
 4. Veterans care for service-connected-disability.
- Ten important bills to watch and guard against were:

1. Universal Military training of doctors.
2. Extension of social security to include physicians.
3. Federal aid to private health insurance plan.
4. Free hospital benefits under old age and survivors act.
5. Doctors' draft.
6. Federal aid to medical education.
7. Permanent total disability insurance.

The speaker urged every one to know his congressmen and to become acquainted with them.

CIVIL DEFENSE

The conference was urged to awaken doctors to the necessity of civil defense. The President, Mr. Eisenhower, is conscious of preparation for any emergency. Doctors should be. If we have a disaster patients will run to a hospital and hospitals may be

blown up too. Individuals should know what to do and where to go first.

NURSE RECRUITMENT

Mrs. M. L. Henry of Oklahoma talked on loans versus scholarships. One out of every four nurses in their state failed to complete her nursing course on scholarship and two out of twenty failed on loans. Oklahoma has shifted from scholarships to loans. Those accepting loans are more interested in their future and expect to pay when they graduate. No time restriction is placed on them. The loans are created in the same manner as scholarships and are perpetual.

MENTAL HEALTH

Dr. Richard Plunkett said mental illness is primarily an educational problem.

1. The important step is to educate the public.
2. Interest Public Schools in the problem and make it part of their program.
3. Help create better institutions.
4. Good public relations with Health Organizations.

TODAY'S HEALTH

Mrs. Richard Stovie, Chairman.

Mr. Robert Enlow, Director of Circulating Department.

Selling suggestions were:

1. Contact other groups to talk up subscriptions through your Auxiliary.
2. Work through doctors' offices.
3. Give gift subscriptions.
4. Give subscriptions to new mothers.
5. Beauty shops subscriptions.
6. Christmas gifts.

Have a speaker talk on, "America's No. 1 Killer is Overweight." Read "Today's Health."

RURAL HEALTH

This panel concerned other communities more than Maryland. In some sparsely populated areas public relations were very necessary in aiding the doctors to build clinics and to plan P.G. courses for young doctors. One doctor's wife reported that she took a young doctor into her home and did his laundry. The panel urged the community to use the new doctor rather than go to a distant city.

ORGANIZATION

Mrs. Flanders, Chairman.

Organization was discussed on county level.

1. Have committee on membership remember widows and retired doctors' wives.
2. Encourage medical societies to place a check before names of doctors whose wives are Auxiliary members when they print the roster.

BULLETIN

Mrs. Simonds, Chairman of Bulletin, gave us an acrostic on the Bulletin.

B—be a good subscriber.

U—utilize all contents.

L—look at all pages.

L—leading facts.

E—every member a subscriber.

T—timely tools.

I—inside information.

N—needs your support.

The bulletin is the president's best friend. Many problems are answered here. The county chairman cannot do a good job if she does not subscribe.

On Friday we had a very interesting tour through the A. M. A. Building. For those who have never been there, it is a must to go through this eight story building at 535 N. Dearborn Street, Chicago, Illinois. Starting from the top floor where the Auxiliary offices and auditorium are located, we toured down to the sub-cellar of this great institution.

We visited the following Councils:

- Medical Education and Hospitals
- Pharmacy and Medicine
- Research
- Food and Nutrition
- Physical Medicine and Rehabilitation
- Industrial Health
- Medical Motion Pictures
- Cosmetics
- Laboratories
- Exhibits
- Investigation
- Publications
- Legislation
- Rural Health
- Public Relations

We also visited the A. M. A. Library, one of the most outstanding in the world.

All of these departments had well equipped offices, manned with trained personnel. Every doctor in the United States should visit this institution. He would feel that the dues he pays to the A. M. A. are a great investment.

Following the tour, we saw two films, sponsored by the A. M. A.:

"Operation Herbert"

"A Citizen Participates"

Then we viewed our own Maryland film, "The Girl with the Lamp." When I saw the film and heard the enthusiasm that followed, it was a vision realized and a feeling of a job well done. No one but Mrs. George Yeager, Mrs. Edward Stewart and their committee will ever know the Blood, Sweat and Tears that went into the work of this production.

From the experience gained with this project, I suggest if one has an idea that he thinks is good for the betterment of the work he is deeply interested in, do not let it die. Take it to someone who can help develop it. People are ready to grasp new ideas if they are worthwhile.—Only hard work will bring results.

LUNCHEON MEETING

WOMAN'S AUXILIARY TO THE
MEDICAL AND CHIRURGICAL
FACULTY*

Introduction of Guest Speaker by Dr. Maurice C. Pincoffs

DR. PINCOFFS: Due to the kindness of your President, I have the honor of introducing the speaker of the occasion. This man on my right has had a very remarkable career. There is a theme that runs through it; one of broad interests, and one of success. He has been many things.

Shortly after graduation, he entered on a long career in the army as a regular Army Medical Officer. He showed his gift in the way of foresight in that he very promptly took up an interest in the embryonic Air Force and rose to be commandant of the first school of Aviation Medicine. He never gave up that interest.

After he left the army, he became the first Medical

* Annual Meeting, April 29, 1953, Sheraton-Belvedere Hotel, Baltimore.

Director of Civilian Aviation, and to this day he is the Chief Editor of the Journal of Aviation Medicine.

He entered into practice and at once showed an interest not only in clinical medicine but in public health, and became a member of the Council of Public Health in the State of New York. He started his County Medical Society membership in Nassau County, New York, and soon was President.

Later, he became a delegate to the American Medical Association. It was not long before he was a Trustee of the American Medical Association. Soon after that he became Chairman of the Board of Trustees of the A. M. A., and then as you know, President-elect and now President.

In all this activity he has found time to become a diplomate of the American Board of Cardiology. He has delivered many papers on Cardiology, and has also developed an active practice in that field.

Dr. Bauer probably advises his patients often to cut out some of these numerous activities and to get plenty of rest. The kind of man you are going to hear is a man who was in Des Moines yesterday, and will be in New Orleans tonight. In other words he is a typical physician, he does not follow his own advice.

I am sure that the husbands here will agree with me that if I stopped at this point, I'd be greeted with questions concerning whether our guest is a married man and if a married man his wife's maiden name and how many children. I have hunted about a bit to get more exact details knowing I was to introduce Dr. Bauer, but these vital statistics were not readily available.

Through his kindness, I can now tell you something I am sure you did not know. This man of foresight and vision is married, and his wife is a Marylander, she was Miss Margaret Buckler of St. Mary's County. He has two children, a daughter and a son and four grandchildren.

I think we all would like to pay tribute to our guest. I am sure all of you feel as I do that he is a man who has shown throughout his career—and I have only mentioned a part of it—an extraordinary breadth of interest and an extraordinary ability to go to the top, whatever he undertakes. Also, I am sure that all the husbands will agree with me that one example is that he found his wife in Maryland. Dr. Bauer.

(Audience rises in tribute)

Address by Louis H. Bauer, M.D.*

DR. BAUER: Thank you, Dr. Pincoffs. Madam President, Distinguished Guests, Ladies and Gentlemen:

I am very glad to have the opportunity of being here in Maryland. I have been here many times before, but never in an official capacity.

I don't know whether Dr. Pincoffs' remarks show anything other than that a man can easily be sucked into a lot of things without realizing it. I once made a remark years ago that if a man wanted to protect himself in organized medicine, if given a job he shouldn't do it at all or do a lousy job so nobody would ever ask him to do anything again. If you do a job anybody admires half way, then you're licked.

I would like however, to urge the members of the medical profession to take more interest in medical affairs other than a strictly scientific one, because that is one of our difficulties at the present time. Too few doctors think outside of the scientific realm of medicine, and if we are to continue in the United States the system of medicine which we have, then doctors have got to take an interest in the social and economic side of medicine as well as in the purely scientific aspect.

Our County Societies in most areas of the country—I don't know how it is here in Baltimore—but I know, by going around the country, these County Societies are poorly attended. The result is that the County Society has lost a great deal of influence it formerly had in health affairs in the community, because of a lack of interest.

The public is taking an increasing interest in medicine but it needs leadership and there is no one who can give that leadership to the community like the doctor. If he does not do it then somebody else will and the leadership will not always be of the best interest to either the public or to medicine itself.

We hear a great deal about the American Medical Association and not all of it is complimentary. I think perhaps some of the difficulty has been that during the last four years we have had a fight on our hands and that particular fight has been headlined in the newspapers to the exclusion of everything else the Association does. People have begun

* President—American Medical Association, 1953.

to think of the Association as being a political organization where, as a matter of fact 90% of the activities have been in the scientific field and always will be.

The American Medical Association, I think, has been taken for granted by too many doctors. They have not realized what the Association has done for them. I frequently hear "why should I belong to the A.M.A., what did it ever do for me?"

May I say the entire environment of medical practice today, and the system under which you practice, is due to the American Medical Association. There is no medical organization in the world which has done so much for the general public or for the practitioner as has the American Medical Association.

I recently returned from a trip around the world and I was quite startled to find that many doctors in other hemispheres know more about the American Medical Association than a lot of doctors here in the United States. They wish their organization could be patterned after the American Medical Association and be as influential as that organization is.

Now why do I say the American Medical Association has done more for the public than any other organization? Let us look back a little bit. Half a century ago, medical education was at a low ebb in the United States. At that time the American Medical Association decided to engage in a campaign to raise the standard of medical education in this country. A lot of rocks were thrown at the Association particularly by those concerned with the so-called proprietary school of medicine. Nevertheless the campaign went on, and as a result it represents one of the finest things the American Medical Association did for medical education because today it is not excelled anywhere in the world.

This country has become the center for medical training, whereas half a century ago our doctors used to go elsewhere for their training. Now, foreign doctors come here for their training.

About the same time there were no standards whereby the public or profession could judge the value of a drug or therapeutic agent. Gradually various councils like the Council of Pharmacy and Chemistry, the Council of Food and Nutrition and the Council of Physical Medicine and Rehabilitation were developed to make appropriate studies.

To-day the result is that if a drug or apparatus has the seal of approval of the American Medical Association it is reliable. You thereby know it is a drug based on sound pharmacological and clinical experience, and that it is not a secret remedy; that the formula is open to anybody who wants to read it; that it has been tested; that as far as anyone can tell it is without danger or if there is a danger the danger is plainly marked on the preparation; and that there is no unwarranted claim made as to its efficacy.

Standards in industrial health have been raised. The Council on Rural Health has done a tremendous job through cooperation with the National Grange and the National Farm Bureau, in raising the standard in rural areas and making medical care available in rural areas. There is no aspect of medicine which has not been affected by the American Medical Association, yet people do not stop to realize but take all this for granted.

Now, with any large organization—and there are 140,000 members of the American Medical Association—there are bound to be differences of opinion. That is healthy. There'd be no use having an association if everybody thought exactly alike. We must remember however that the majority has to rule until the minority can persuade the majority that they are wrong.

We hear a great many claims about the American Medical Association being a hierarchy and undemocratic. Well, I think that the American Medical Association is probably the most democratic, large organization that I know. How are its policies determined? You doctors belong to County Societies where you have a vote; you elect delegates to your state organization and those delegates in turn elect delegates to the American Medical Association. Thus they form the policy-making body of the American Medical Association. Delegates from the states are in proportion to the number of member doctors of the Association. All legislation and all policies are adopted by the House of Delegates of the American Medical Association, more or less similar to Congress. When resolutions are introduced, they are referred to the Reference Committee. The Reference Committee holds open hearings to which any member of the Association regardless of whether he is a member of the House of Delegates, may appear and testify for or against

that particular report or resolution. You don't have to belong to the policy-making body to make your wishes and desires felt. A lot of doctors don't know that.

When the Committee has heard all the testimony it reports back to the House of Delegates. You have more privilege than you have with Congress. Congress limits the time to hear people. There is no such limitation in the American Medical Association.

Now, as to hierarchy. I was elected in 1944 to the Board of Trustees. When I was named President-Elect in 1951, there was not a single person on the Board who was there in 1944. You don't have a hierarchy with such a turnover.

We hear a great deal about needing more doctors. I think we need slightly more doctors and we are getting them. What we need most is a better distribution of doctors. We have in the United States about one physician to every 750 persons, which is more than any other country in ratio of population by 25%. Our nearest competitor is Great Britain with one doctor to every 1,000 persons. Our doctors are not well distributed. In New York City there are one to every 450 persons, and in the South there is one to 1,800.

How are you going to get doctors from the city to go into rural areas? Not by doubling or tripling them, they will congregate in a city. There is only one way and that is by affording them facilities to practice good medicine. No doctor who spends ten to thirteen years of his life in training to be a physician and practice modern medicine is going to settle in a community where he has to practice an archaic type of medicine, and you can't blame him for not doing it.

The question has to be solved by setting up facilities, attracting and selling by amortization over a period of years. Where that is done there is no trouble getting doctors into rural areas. We must urge communities to see that these facilities are available in order to obtain doctors.

We need more widespread public health facilities than we have. Where Public Health stops and where it begins has been argued. At least we can agree environmental sanitation, production of good milk, water supply, prevention of communicable disease are areas for public health officials because they

have to be carried out on the community basis and some require police power.

Then we need a program for caring for chronic invalids. That means not only chronic disease like Cancer and Tuberculosis but also degenerative diseases which accompany old age. We have commissions on chronic illness, trying to solve this problem, I hope within the next year they will come up with an answer. We have an aging population. The reason we have a great number of people with chronic degenerative disease is because they have had good medical care; the span of life has increased 21 years in the last half century. The result is that millions of people are now living to middle and old age who would have died in infancy and childhood. Heretofore they would have died before they reached old age, and unless we find some method of preventing or controlling these degenerative diseases, the problem will be an increasing one. It is an increasing one, too, because of what I consider the stupid, economic ideas which we have in this country, that everybody who is sixty-five years old should be put on the shelf. I don't know of any way to kill anybody when he has been active than to make him retire and do nothing. But we are working on those things and I hope the solution is going to be found.

Another gap in our program is Care for the Indigent. Some States have very satisfactory programs for the care of the indigent, others do not. But that is no reason why they should not have it in every area. To have it so there is good cooperation between the Welfare Department—or whatever department it is in the State that handles the care of the indigent and the aged, and the medical profession.

Further, we must expand our Voluntary Health Program. It is growing by the millions each year. We now have nearly eighty million people covered for hospital expenses. We have another sixty-six million protected against surgery and maternity, and another thirty million insured against medical care in whole or in part.

There are two groups requiring protection in the Voluntary Insurance Program. One is protection of people over 65;—that is rapidly being taken care of. We need voluntary plans to start with. If Voluntary Insurance Plans never had anyone but people over sixty-five, they'd have gone bankrupt quickly. But now they have a sound footing and are able to cover

that group. More and more plans are increasing the age limit and many of them now have no age limit. Once you're in, you're in as long as you live so long as you pay the premium.

The other is insurance against long duration illness—the person sick for a year or two years. Only a small proportion of the population are subject to such illness but nevertheless some method must be found to give them protection in case they do suffer from such a long, drawn out illness. And those two things have got to be worked out, and can be worked out on a voluntary basis in my opinion, without having to go to the government to get them to finance it and which I think would be disastrous.

One other thing I think the profession can do and that is the development of leadership in the community. Community Health Councils are being formed in various areas because medicine is no longer an individual matter between doctor and patient. It involves the Dentist, the Nurse, and in the case of low-income groups, Social Welfare, Public Health officials, etc. They must work together as a team. The voluntary health agents come in too. Particularly in certain groups they must make a team to solve these problems together. And there is no one who is better qualified than the doctor and I urge that he take an interest in the community and develop civic responsibility as well as scientific responsibility.

I think all of these problems can be worked out through our American way of life without having to adopt the schemes in vogue in other countries; in fact in most other countries. I have visited Europe twelve times in the last six years and went around the world once last fall. I have had an opportunity to see a lot of their schemes first hand. Now I don't want to criticize any country for what that country does; that is their own business. But I can say this, whether or not these plans work well in that country, I have yet to see one I want to see adopted in this country. Every one that involves participation by the government is bankrupt. All are operating in the red. The way the government endeavors to reduce debts is to restrict benefits to the patient, restricting medicine and treatment by the doctors, and, of course, remuneration to the physician so it becomes an assembly-line type of medicine.

Socialized Medicine I think is no longer an immediate danger in the United States, but we must

remove these gaps in the program which I have mentioned, and if we do that I think we can permanently keep that danger away.

One other item on the domestic level is Medical Education. Our medical schools have been in a tough spot financially. That is due to the high tax laws we have now, which have been drying up private philanthropy, and there aren't any large fortunes left. Consequently the schools are having difficulty in getting money to continue operation at a high level.

There are two schools of thought on the problem. One, is that funds can be raised through private enterprise, and the other it can be raised by government contribution. Some people say, why not have the government participate in medical education, the government is the only one who has money and it probably wouldn't control medical education anyway. I disagree on both counts. In the first place the government hasn't any money which it doesn't take out of your pocket and mine. In the second place I'm not sure the government wouldn't endeavor to control medical education if it got its foot in the door. In my inaugural speech last June, I cited an instance where the divisional education had reprimanded a teacher in the mid-west because he expressed a personal opinion. He was told the publicity given to his comments might result in the entire area being excluded. If they do that because somebody cites a personal opinion we cannot be too sure they won't open their area to controlling medical education. I don't think that is a danger at the moment but you have to look with a long range viewpoint.

Suppose the government did subsidize our medical schools for a brief period. We now obtain certain funds from private sources; those funds would dry up; the people would say the government is doing it then why should we contribute, and then if the government withdrew or refused to support it, the schools would be worse off than now.

Every physician has a responsibility to his medical school. No doctor paid for his medical education. He paid tuition but that is all, and maybe that represented no more than one-third of the cost to the school educating the doctor. The rest came out of endowment.

Now, endowments are shrinking, and incomes from investments are shrinking and schools no longer have

sufficient funds to meet that deficit and we have to get it from somewhere if we do not want it from government. We must get it from industry and doctors. I hope every doctor will feel that he does have an obligation to his school whether he contributes directly to the school or to the medical foundation. He should give something to the school to repay the debt which he owes the school. If he contributes to the American Medical Education Foundation the Foundation will either distribute it among all of the schools or if an individual school is specified it will go to that school. Every dollar you contribute goes to the school. Not one cent is deducted for administrative purpose.

One other item I would like to mention, we don't have much danger of socialization from domestic level but we do have a little danger from the international level.

There are more and more problems which are being discussed and decided on the international level which pertain to health and medicine. One of the international organizations which is having a good deal to say about medicine, particularly in the field of Social Security is the International Labor Organization, which has been in existence for twenty years in the United States. I don't know whether you know much about ILO or not. Each year they hold a convention; two men represent the government, one represents management, and one man represents labor. Last year they discussed the medical aspects of Social Security; they brought in a report which recommended compulsory health insurance or government controlled voluntary insurance for every nation adhering to ILO. All they need to put that into effect is for the United States to adopt it as a treaty and you'd have it, and the House of Representatives wouldn't have a thing to say about it.

Now the World Medical Association found out about this and drafted a report representing what the doctors think of the Medical aspects of Social Security and went to the ILO and asked that they distribute our report as well as the one they compiled and they refused to do it. We got it distributed but not through any help of theirs. That report went into the Journal of the American Medical Association of May 31st last year. Many of you may have seen it.

The World Medical Association is an organization

of National Medical Associations, and may I differentiate from the World Health Organization. The World Health Organization is a branch of the United Nations and represents governments in the field of Health—more particularly in the field of Public Health. The World Medical Association, however, represents the doctors and there are now forty-three nations within its fold comprising within the National associations of those forty-three nations about seven hundred thousand doctors. I think the voice of those doctors should be heard when it comes to matters pertaining to health and medicine. Without the World organization there was no one to speak for the practicing physician. Everything is being discussed and decided from the government viewpoint.

Government has a place in Medicine which I mentioned already but Government should keep in its place rather than interfere in medical care per se, or doctor-patient relationship. But without anyone to speak for you, these things will be decided without your voice, whatever.

We have set up in this country a committee known as the U. S. Committee of the WMA, in which memberships are passed and we have agreed to underwrite expenses of the association and the members have all our publications including the bulletin.

Now these doctors throughout the world, I have found, think surprisingly alike and it is also interesting to know they seem to have the same problems no matter where they come from. Those problems may differ in degree but they are the same basic problems and the doctors may differ as to details how the problem should be answered, but basically they think the same.

In other words, medicine has proved to be a universal language and when you start with that as a basis you find that suspicion and distrust quickly disappear, and these doctors when they congregate together find that the fellow from the other country doesn't have horns or a fork-tail after all.

So I feel doctors can do more in improving relations than the diplomat agent. We have shown that through the WMA. One of the differences is language. We deal in English, French and Spanish. Those who know more than one language know how difficult it is to translate words and have them mean the same thing in another language. You must translate the idea back of the word. In 1948 when the World

Organization was meeting they spent a day and a half arguing about twelve principles, but ninety-five per cent of the arguments were through difficulties because of language. The minute all language barriers were removed those twelve principles were adopted unanimously and there were thirty-one nations present at the time they were adopted. So I do think it speaks well when doctors speak alike.

There is a story, in the First World War about a Japanese cruiser chasing a German Gunboat into Guam Harbor. One of the German officers fell in love with an American nurse but had a difficult time because he could not speak English. He wrote a letter and by dictionary translated it into English. One of those letters made a hit because she married him. "The fragrance of your presence intoxicated me." When translated: "The smell of your body makes me drunk." I think this illustrates you cannot translate the words. He had the idea but didn't quite get the words.

I probably have talked long enough and you have meetings this afternoon. I want to pay tribute to the Auxiliary. There are a lot of things doctors could do but won't and the wives do it for them. We could have been behind the eight ball a number of times had it not been that the Auxiliary pitched in and helped out. I understand you are a young Auxiliary

but I am sure you will be able to do a great many things for the medical profession. To give an illustration, one State whose name I won't mention, had a woman legislator. A bill was going to be introduced which was greatly opposed by the whole medical profession—it had to do with quackery—and it was said the bill was to be introduced by this woman legislator. Of course if we had asked the doctors to do anything there would have been a half dozen who would have sent a telegram. But within a week in that State, the women of the Auxiliary bombarded her with over a thousand letters until she threw up her hands and asked them to get the women off her neck, that if she had ever intended introducing the bill she certainly wouldn't now.

So you see how effective the Ladies' Auxiliary can be. Now in closing, I want to thank you for your hospitality. I appreciate the opportunity of having been here and I wish you a most successful meeting.

(Applause) (Audience rises in ovation)

MRS. WILLIAMS, AUXILIARY PRESIDENT: Thank you very much, Dr. Bauer. Our warmest thanks for your message and for your presence in Maryland.

(Applause)

A. M. A. INDORSES BILL FOR EXPANDED HILL-BURTON PROGRAM

A. M. A. Washington Letter—No. 57

The American Medical Association has given its formal indorsement to the first of the administration's health bills, a 3-year, \$60,000,000-a-year program for Hill-Burton grants to build non-profit facilities for the chronically ill, nursing homes, diagnostic or treatment centers and rehabilitation units. The Association's position was outlined in a letter from Dr. George F. Lull, A. M. A. secretary and general manager, to Chairman Charles Wolverton of the House Interstate and Foreign Commerce Committee. The committee opened hearings on the bill (H. R. 7341) Feb. 4, immediately after winding up an extensive fact-finding study of health problems. The first witness was Mrs. Oveta Culp Hobby, Secretary of Health, Education, and Welfare, who urged favorable committee action.

The A. M. A. recommended that: (1) facilities for the chronically ill and impaired should be part of or near a conventional hospital, (2) the original purpose of the Hospital Survey and Construction Act (Hill-Burton) should be reaffirmed to make clear that any facilities built under the new program are for the benefit of the entire community.

ARTICLES OF INTEREST

DR. WALTER L. KILBY

Dr. Walter L. Kilby has recently resigned as Director of the X-ray Department of the University Hospital and Professor of Roentgenology of the University of Maryland Medical School in order to devote his entire time to the private practice of Roentgenology.

Dr. Kilby came to Baltimore in 1936 to become associated with Dr. Henry J. Walton. At that time he was appointed instructor in Roentgenology and Assistant Roentgenologist at the University of Maryland Medical School and Hospital. He was later promoted to Assistant Professor in Roentgenology, a position held until 1941 when he was appointed acting Professor of Roentgenology and Director of the X-ray Department following the resignation of Dr. Henry J. Walton who had held the position for about 30 years.

In 1940 Dr. Kilby was commissioned as Lieutenant in the United States Naval Reserve. Subsequently he was transferred to the Army where he received a commission as Major and was assigned to the University of Maryland sponsored 142nd General Hospital. He went overseas with this unit and served 27 months in the Fiji Islands as Chief of X-ray Service and later followed the unit to Calcutta, India where he served for 6 months. He was returned to the United States in April 1945, having been promoted to Lieutenant Colonel, and assigned to the Woodrow Wilson General Hospital, Staunton, Virginia as Chief of the X-ray Service.

Dr. Kilby was discharged from the Army in September 1945 at which time he returned to the University of Maryland and was appointed Professor of Roentgenology and Director of the X-ray Department of the University of Maryland Medical School and Hospital, a position he held until his recent resignation.

Dr. Kilby was born in Rappahannock County, Virginia where he received his early education. After graduating at the University of Virginia with a B.S. degree he devoted three years in the educational field. He entered the University of Virginia Medical School in 1929 and received his M.D. degree in 1933.

After spending a year at the Cincinnati General Hospital, Dr. Kilby returned to the University of Virginia Hospital where he remained two years as Assistant Resident and Resident Roentgenologist.

During his stay at the University of Virginia, he became a member of Phi Delta Kappa, Phi Chi Medical Fraternity, Alpha Omega Alpha and Iota Sigma, the latter two being honorary medical fraternities. Dr. Kilby was elected to the Raven Society, an honorary scholastic society, in 1932 and the same year he was elected president of the Medical School.

Dr. Kilby is a member of the American Roentgen Ray Society, The Radiological Society of North America, The American College of Radiology, The American Medical Association and the Baltimore City Medical Society. He has served as secretary and treasurer and chairman of the Radiological Section of the Baltimore City Medical Society.

FRANK KUEHL JOINS WASHINGTON STAFF

The AMA Washington Letter, No. 56

Frank Kuehl, an attorney with the Reconstruction Finance Corporation since 1933, will join the Washington Office of AMA as legal adviser. Before coming to Washington, Mr. Kuehl was assistant attorney general in Wisconsin for six years.

Book Reviews*

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them.

The Nursing Mother. Frank Howard Richardson, M.D., F.A.C.P., F.A.A.P., Licentiate American Board of Pediatrics. Pediatric Introduction by Clifford G. Grulee, M.D., Founder of the American Academy of Pediatrics, Chicago, Illinois. Obstetric Introduction by Nicholson J. Eastman, M.D., Obstetrician-in-Chief, Johns Hopkins Hospital, Baltimore, Maryland. Copyright 1953. Prentice-Hall, Inc., Publishers. 204 pages. Illustrated. \$2.95.

Breast feeding of the newborn has always been the rule among the poorer peoples of the world. Recently many modern mothers have found it necessary or have chosen to seek employment or a career; others have found the need for increased social life with less emphasis on household duties. Such desires or necessities have reduced the incidence of breast feeding in the more financially stable group of peoples. Many mothers are of the opinion that breast feeding can be successful by only a select few. All of these reasons have reduced the total number of breast feedings in the United States. This has been the reason for the writing of this book.

Dr. Richardson believes that most mothers can breast feed their infants if properly instructed; that breast fed babies thrive better than bottle fed infants. He produces evidence to show the superiority of breast feeding; he spends many chapters describing the proper method of preparation for breast feeding, the proper management of the infant during feeding, and the infant's behavior at this time; and finally he reemphasizes his material by using a question and answer method of instruction.

This volume is very well written, it maintains interest and is well printed. It should be a valuable aid to the pregnant and puerperal woman, and also a valuable guide for the obstetrician and pediatrician.

D. F. K.

Brain Surgeon. The Autobiography of Dr. William Sharpe. Director of Neurosurgery, Manhattan General Hospital, New York City. Foreword by John Haynes Holmes. Copyright 1952 by William Sharpe. The Viking Press, New York, and The Macmillan Company of Canada Limited, Publishers. 271 pages. \$3.75.

This is an autobiographical account of the career of Dr. William Sharpe, one of America's pioneer neurosurgeons. The son of a Scotch Presbyterian clergyman,

*The reviews here published have been prepared by competent authorities and do not represent the opinions of any official bodies unless specifically stated.

he states that his boyhood was spent in the slum areas of Pittsburgh, Chicago, and later Philadelphia. His success as a student at Harvard and during his four years in medical school and three years of hospital internship is attested to by the fact that during these ten years he earned approximately fifty thousand dollars by tutoring what he called "slothful students." In a fascinating manner the author relates his adventures as a graduate student in various European Universities, as a neurosurgical trainee under Dr. Harvey Cushing, and then as the first professor of surgery at the then newly established Harvard Medical School of China.

There then follow interesting and uninhibited accounts of the neurosurgical triumphs and failures of Dr. Sharpe and his contemporaries. The author, by virtue of his prominence in the medical profession and his vast and varied travels, is able to present to the reader interesting and informal aspects of the lives of people politically eminent as well as those renowned in the field of medicine.

Dr. Sharpe states that his reason for writing this book "in the first place" is to set forth his ideas on "the prevention of cerebral palsy by improved prenatal and obstetrical care so that the danger of intracranial hemorrhage at birth is minimized." Throughout the book the author repeatedly refers to the importance of intracranial hemorrhage in the newborn as a cause of cerebral palsy and the necessity of repeated spinal punctures until the bloody spinal fluid becomes clear. He very appropriately cautions that all cases classified as cerebral palsy are not born of such an etiology.

On November 9, 1915 Dr. Sharpe read a paper before the New York Academy of Medicine on this subject, and on the following day, much to the dismay of the author, the newspapers had "in a garbled and dramatic style" outlined his presentation on the first page. "Within a week my neurosurgical clinics at the Polyclinic were increased by the arrival of spastic children of all kinds. Unfortunately the vast majority of these cases were so badly impaired that little could be offered to improve their condition other than by massage and exercises." It is to be hoped that the lay and uninitiated reader will read carefully and understand the words of the author lest once again false hopes invade these many pathetic households.

W. H. M., Jr.

COMING MEETINGS

You Are Cordially Invited to Attend

The

THIRD ANNUAL PEDIATRIC SEMINAR

Sponsored by the Pediatric Department, University of Maryland, School of Medicine

Sunday, March 28, 1954

GORDON WILSON HALL, UNIVERSITY HOSPITAL, BALTIMORE, MARYLAND

10:00-10:05 Welcome. Dr. J. Edmund Bradley

10:05-11:00 The Management of Common Pediatric Cardiac Diseases. Dr. Rachel Ash, Associate Professor of Pediatric Cardiology, University of Pennsylvania, School of Medicine.

11:00-11:30 Discussion.

11:30-12:30 Practical Aspects of Liver Diseases in Pediatrics. Dr. Sydney S. Gellis, Assistant Professor of Pediatrics, Harvard Medical School, Senior Physician, Children's Medical Center, Boston

12:30-1:00 Discussion.

1:00-2:00 Lunch will be served in the auditorium on the fifth floor.

Moderator, Dr. C. Loring Joslin, Professor of Pediatrics, University Hospital

2:00-3:00 Early Diagnosis and Treatment of Tuberculosis in Children. Dr. Edwin L. Kendig, Jr., Assistant Professor of Pediatrics, Medical College of Virginia

3:00-3:30 Discussion.

3:30-4:30 Some Dermatologic Problems Seen in Pediatric Practice. Dr. Marion B. Sulzberger, Professor and Chairman, Department of Dermatology and Syphilology, New York University, Postgraduate Medical School, Director, New York Skin & Cancer Unit.

4:30-5:00 Discussion.

Committee on Arrangements: Edward G. Field, M.D., Samuel Shipley Glick, M.D., and Ruth W. Baldwin, M.D., *Chairman.*

POSTGRADUATE COURSES

Presented by the Baltimore City Medical Society, its Sections, and the Maryland Academy of General Practice.

DISTURBANCE OF WATER AND ELECTROLYTE METABOLISM

NEW CLASS ROOM—THE JOHNS HOPKINS HOSPITAL

Thursday Evenings, 8:00 p.m.

April 1, 1954 Some Physiological Background to Problems in Water and Electrolyte Metabolism J. L. Lilienthal, Jr., M.D.

April 8, 1954 Mechanisms and Treatment of Water and Electrolyte Disturbances in Medicine Kenneth L. Zierler, M.D.

April 15, 1954 Water and Electrolyte Disturbances in Pediatrics and in Diseases of the Nervous System. Harold E. Harrison, M.D.

April 22, 1954 Water and Electrolyte Disturbances in Surgery Eric Nanson, M.D.

NEUROPSYCHIATRIC SECTION

LEONARD J. GALLANT, M.D., *Secretary**Thursday, April 8, 1954, 8:30 p.m.**Faculty Building, 1211 Cathedral Street*

Some Considerations of the Interrelationships between the Hypothalamus, Anterior Pituitary, and Adrenal Cortex in the Response to Stress. Frank Engel, M.D., Associate Professor of Medicine, Duke University, Durham, North Carolina.

Discussants: Enoch Calloway, M.D., Instructor in Psychiatry, University of Maryland School of Medicine.

Jacob Finesinger, M.D., Professor of Psychiatry, University of Maryland School of Medicine.

RADIOLOGICAL SECTION

David N. Gould, M.D., *Chairman*H. Leonard Warres, M.D., *Secretary**Tuesday, April 20, 1954, 8:00 P.M.*

Brief important business meeting and election of officers for the coming year.

DOCTORS HOSPITAL

INSTITUTE OF POSTGRADUATE MEDICAL STUDIES

Tentative Program

INDUSTRIAL AND TRAUMATIC MEDICINE AND SURGERY

OPENING SYMPOSIUM—Tuesday Evening, April 13th—9:15 P.M.

"Occupational Disability and The Doctor's Testimony"

LECTURES—

1. Wednesday, April 14
 - a) 3:00 P.M. Treatment of Eye Injuries
 - b) 3:30 P.M. The Ear in Industry
 - c) 4:00 P.M. Occupational Affections and Injuries of the Nose.
2. Wednesday, April 21
 - a) 3:00 P.M. Treatment of Burns
 - b) 3:30 P.M. Dermatoses
 - c) 4:00 P.M. Hand Injuries
3. Wednesday, April 28
 - a) 3:00 P.M. Pulmonary Diseases Due to Environment

PANEL DISCUSSION—Tuesday Evening, May 4th—9:15 P.M.

"Syndromes Arising from Skeletal Trauma"

Moderator—

"Head Injuries"—

"Cervical and Low-back Syndromes"—

"Fractures and Dislocations"—

LECTURES—(Continued)

4. Wednesday, May 5

- a) 3:00 P.M. Fatigue, Stress, and Malingering in Industry
- b) 3:45 P.M. Menstrual Disturbances and Pregnancy in Industry

5. Wednesday, May 12

- a) 3:00 P.M. The Heart and Blood Pressure in Occupational Disability
- b) 3:45 P.M. Peripheral Vascular Diseases due to Occupation

6. Wednesday, May 19

- a) 3:00 P.M. Radiation Hazards
- b) 3:30 P.M. Acute and Chronic Poisonings

CONCLUDING SYMPOSIUM—Tuesday Evening, May 25th—9:15 P.M.

"Medico-Legal Aspects of Sudden Death from Disease or Injury"

Course under direction of Wm. Schuman, A.B., M.D.

Open to all physicians

Registration required

Address all inquiries and registrations to:

Postgraduate Institute

Doctors Hospital

2724 N. Charles St.

Baltimore 18, Md.

A.M.A. NEWS RELEASE—WASHINGTON OFFICE

THE MONTH IN WASHINGTON

Washington, D. C.—Some parts of the Eisenhower administration's broad health program are making good progress on Capitol Hill, while others are virtually standing still or bogged down in the technical complications that are always a threat to new legislation. Well ahead of the other proposals, and possibly destined for enactment, are bills to broaden the scope of the Hill-Burton hospital construction law and to liberalize income tax deductions for medical expenses.

The House Interstate and Foreign Commerce Committee, under chairmanship of Rep. Charles Wolverton (R., N. J.), wound up its long fact-finding study of voluntary health insurance plans and immediately started hearings on the Hill-Burton changes. The purpose is to amend the Hill-Burton law so that it can be used to disburse federal grants to states for construction of health facilities that do not qualify as "hospitals." The administration is anxious to stimulate the building of more nursing homes, hospitals for the chronically ill, diagnostic or treatment centers and rehabilitation facilities.

An initial appropriation of \$2 million would be authorized for surveys and planning, and \$60 million annually for three years of construction. Per capita income as well as population would be used to determine a state's share, as under the present Hill-Burton program.

At the House hearing, crowded into two days, the construction program was indorsed at least in principle by every witness, except the representative of the American Association of Nursing Homes. Because the program is limited to non-profit sponsors, members of this group could not receive grants. Their spokesman said long-term loans through the Small Business Administration would help solve their problem.

American Medical Association recommended passage of the bill, but urged that facilities for the chronically ill and the handicapped be "part of or near a conventional hospital," and that facilities of all types be open to the entire community without discrimination, as in the present Hill-Burton law. (It is likely hearings also will be held on this legislation in the Senate.)

The House Ways and Means Committee, meanwhile, was giving its approval to a new income tax provision that would allow the deduction of medical expenses if they exceed 3% of adjusted gross income, rather than 5% under present law. The present maximum limitation would be doubled, and the deduction of travel expenses allowed where travel is prescribed by a physician. These changes—a long-time AMA goal—are embodied in the omnibus tax readjustment bill.

President Eisenhower's proposal for federal reinsurance of voluntary health plans has not been able to follow the steady course on which it first appeared to be embarked. At the House hearings, none of the spokesmen for the large organizations in the health fields—AMA, Blue Cross and Shield, American Hospital Association—was willing to indorse the plan. Like the AMA spokesmen, most of them wanted first to examine the actual administration bill, which at that time had not been introduced. From the Blue Cross, however, came a suggestion that the idea be tried out experimentally.

Spokesmen for national labor organizations expressed mixed reactions, with some maintaining that reinsurance was a poor substitute for what they believe the country really needs—national compulsory health insurance.

The administration's health budget for the next fiscal year, starting next July 1, calls for a slight overall reduction. The regular Hill-Burton program, currently operating on \$65 million, would get \$50 million (any appropriation to start the proposed expanded construction would be in addition). Relatively sharp reductions would be made in funds for venereal, tuberculosis and communicable disease control, in line with the policy of shifting this responsibility to the states. The various research institutes would receive about what they are now spending.

One of the few new items is for \$7.8 million, estimated as necessary for the extra cost of enlarging the federal program of vocational rehabilitation. Legislation authorizing the expansion is awaiting Congressional action. The administration hopes gradually to increase the number of persons rehabilitated annually from the current 60,000 to 200,000. While the program is being stepped up, one of its goals would be to induce states to increase their spending until eventually their appropriations match the federal. Like most of the President's health program, the rehabilitation effort has the support of the AMA.

Conferences between AMA officials and administration leaders are continuing. Latest sessions were with Secretary Hobby, concerning her department's legislative plans; with VA Administrator H. V. Higley, on treatment of non-service connected cases; and with Adm. Arthur W. Radford, chairman of the Joint Chiefs of Staff, Dr. Frank Berry, Assistant Defense Secretary for health and medical matters, and Dr. Howard A. Rusk, chairman of the Health Resources Advisory Committee, on medical care for military dependents. Representing the AMA at one or more of the meetings were Drs. Walter B. Martin, David B. Allman, Gunnar Gundersen, Louis Orr, James C. Sargent, W. L. Crawford, George F. Lull, Ernest B. Howard and Frank E. Wilson.

Earlier, AMA representatives talked over legislation with President Eisenhower at the White House.

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ADMINISTRATION'S 1955 BUDGET FOR HEALTH AND WELFARE

A. M. A. Washington Letter—No. 57

The Administration has presented Congress with its estimates of spending for medical and related programs during fiscal 1955. The Department of Health, Education, and Welfare budget alone accounts for \$2,321,591,988. It is \$200,000,000 under estimated spending for the current fiscal year, mostly because of a cut in grants to states for public assistance. The following table lists major programs of H. E. W. and medical items of other agencies, but does not include proposed armed forces spending for medical care.

	Estimated Fiscal 1954	Requested Fiscal 1955
<i>Dept. Health, Education & Welfare</i>	\$2,521,897,175	\$2,321,591,988
Public Assistance (grants to states)	1,340,000,000	1,200,000,000
Food & Drug Administration	6,280,200	6,245,000
Office of Vocational Rehabilitation	23,658,100	27,625,000*
Children's Bureau (grants to states)	30,000,000	30,000,000
Public Health Service	232,830,950	191,463,000
assistance to states, general	13,525,000	15,039,000
venereal disease control	5,000,000	2,300,000
tuberculosis control	6,000,000	3,500,000
communicable disease control	5,009,000	4,397,000
Hill-Burton hospital program	65,000,000	55,600,000**
hospitals & medical care	33,117,500	33,040,000
National Institutes of Health (operating expenses)	4,680,250	4,675,000
National Cancer Institute	20,104,775	19,730,000
mental health activities	12,039,575	12,460,000
National Heart Institute	15,169,750	14,570,000
arthritis & metabolic diseases	6,985,150	7,270,000
microbiology activities	5,721,300	5,930,000
neurology & blindness activities	4,501,750	4,763,000
<i>Veterans Administration</i>		
hospital & medical care	693,000,000	694,000,000
hospital construction	84,000,000	60,000,000
<i>Atomic Energy Commission</i>	26,000,000	27,000,000
<i>Civil Defense Administration</i>	22,500,000	60,000,000
<i>National Science Foundation</i>	8,000,000	14,000,000
<i>Bureau of Indian Affairs</i>	52,000,000	54,105,320

* Includes a \$7,800,000 item for President's program of expanded vocational rehabilitation for the disabled.

** Includes a \$5,600,000 item for start of expanded program for clinics, nursing homes.

Note: President also requested a \$1,000,000 item to start proposed reinsurance of health programs.

Annual All-Faculty Dance!

STATE-WIDE BALL TO BE PART OF ANNUAL MEETING,

APRIL 26, 27, 28, 1954



Make reservations early for the MED-CHI FACULTY BALL to be held on Monday, April 26, 1954, dancing from 9 until 1 A.M., at the ALCAZAR, sponsored by the Woman's Auxiliary to the Baltimore City Medical Society.

Be a patron, be present, be prompt!

A variety show with songs and dances entitled "MEDICANA!" will be presented at 10 p.m. Tickets may be purchased at the door. An early return of the forms below will be appreciated.

Please reserve me a table for _____ persons.

Mail to or call:

Mrs. Newland Day
3424 Guilford Terrace
Baltimore 18, Maryland
HO 7-2977

Enclosed please find my check for the patron list. Three dollars minimum patron fee. Make checks payable to the Woman's Auxiliary to the Baltimore City Medical Society.

NAME _____

ADDRESS _____

Mail to or call:

Mrs. Louis Klimes
2412 Lake Avenue
Baltimore 13, Maryland
CH 3-0220